Patient Care Management Manual:

1983 Long Term Care Facility Improvement Program

Department of Health and Human Services
Health Care Financing Administration
Health Standards and Quality Bureau

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The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled and poor. The Agency must also ensure that program beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that Agency policies and actions promote efficiency and quality within the total health care delivery system.

The Office of Standards and Certification of the Health Standards and Quality Bureau, HCFA, is responsible for the development, interpretation and implementation of health and safety standards and other related policies for providers and suppliers of health services under Medicare, Medicaid and other Federal programs of the Department of Health and Human Services (formerly the Department of Health, Education, and Welfare).

This Manual replaces the 1978 *Working Document on Patient Care Management: Theory to Practice* and provides a general survey of the holistic process of assessing, planning, and evaluating long-term care.

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Preface

The Health Care Financing Administration is responsible for, and is committed to, continuing the Department's initiatives started in 1974 to improve the quality of care in long-term care facilities. As part of this goal, this guide to patient care management has been developed. It uses an integrated approach to patient care and includes formal assessment of each patient's needs, a plan of care to meet those needs, and periodic evaluation of the outcomes of care.

A patient care management system has the following advantages; it:

- Gathers information about the patient during the entire process which then becomes the foundation of the patient record
- Involves all personnel—physician, social worker, nurse and others—in a single, comprehensive planning and evaluation process
- Ensures that the focus of patient management is on the full range of the individual's needs, not just on a series of medical problems
- Demonstrates changes in the patient's status, whenever it is repeated at periodic intervals
- Guides patient evaluation in such a way that no important elements are overlooked
- Provides a basis for the measurement of the quality of care

This document provides an overview of a patient care management process and of a model patient appraisal instrument called PACE II (Patient Appraisal, Care Planning, and Evaluation). The appraisal instrument presented here can be used to identify patient needs, which is only one part of a total patient care management system. The process must be followed by care planning and evaluation. PACE II can be used for needs assessment. If another appraisal form is already being used, a facility's personnel may wish to compare it with PACE to assure completeness. Of importance, however, is that any appraisal instrument is only as good as the information entered into it. Thus, careful clinical observations by concerned staff are needed so that what is recorded on an appraisal instrument describes the patient.

Our belief is that through the appropriate application of patient care management the quality of long-term care can be improved and assured. We encourage your participation and support in this important initiative.

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Health Standards and Quality Bureau
Health Care Financing Administration

Foreword

A Patient Care Management System (PCMS) in a long-term care facility is designed to provide a systematic, holistic approach to planning, executing and evaluating patient care on an individual basis. Through appropriate utilization of PCMS, providers should be enabled to: 1) prevent occurrence of major deficiencies in providing services; 2) correct inadequate delivery of health care; and 3) substantially improve the health care system in facilities.

For maximum ease in use, the PCMS Handbook has been published in two parts—a manual and a supplement. The *Patient Care Management Manual* contains uniform instructions and definitions that were derived through extensive testing, and is designed to assist the provider in implementing the system. The *Patient Management Manual: Coordinator's Supplement* contains suggested teaching content and tests that can be self-administered; it should serve as a valuable resource for the teaching of the PCMS concepts.

The PCMS builds on pioneering work carried on in recent years. Numerous voluntary efforts have been undertaken by health professionals for developing methods for assessing and improving the quality of care in long-term care facilities.[1] In 1966 the need to delineate the structure (e.g., staff and organization), process (what providers do), and outcomes, was pointed out with greatest emphasis placed on outcomes (results).[2]

Efforts to adapt this model to long-term care patients have been successful. Notable examples include: Patient Classification for Long-Term Care (Densen, Jones, McNitt, and others); the instrument developed by the Joint Commission on Accreditation of Hospitals; Quality Evaluation System (QES) developed by Rush-Presbyterian-St. Luke's Medical Center and Medicus Systems Corporation. Through the conscientious application of such models by dedicated health professionals, we have seen what can be done. Given the careful application of PCMS, we are confident that we can come even closer to recognizing and defining that elusive entity we call "quality care."

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[1]The various contributions to assessing patients are too numerous to list here. Two recent references are: Murray, Ruth B. and Judith P. Zentner, *Nursing Assessment and Health Promotion through the Life Span*, Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1979; Cornbeth, Terry, "Evaluation of Goal Attainment in Geriatric Settings," *Journal of the American Geriatrics Society*, 26:404-407, September, 1978, No. 9

[2]Donabedian, A. Evaluating the quality of medical care. *Milbank Memorial Fund. Q44(3)* 1966, pt. 2: 166-206; Williamson, John W. *Assessing and Improving Health Care Outcomes: The Health Accounting Approach to Quality Assurance.* Cambridge, Mass: Ballinger Publishing Company, 1978.

CHAPTER 1

Overview

During recent years, much progress has been made in such fields as military tactics, medicine, and systems engineering in creating and refining methods for accomplishing the goals and objectives of important, complex tasks. Regardless of the chosen method, all have certain elements or patterns in common:

- Through analyses of tasks to be done in order to reach a main objective;
- Precise statements of goals for each task stated as results that can be seen or measured and that will occur by a certain time;
- Examination and reexamination of each task at the estimated time it was to be accomplished to see if the task was done;
- Revision of the approach, the goal, or the time, if the task was not accomplished.

This document presents a systematic approach to patient care management in long-term care facilities which also follows this pattern. The fundamental steps in the patient care management (PCM) process are: Assessment, Care Planning, Evaluation/Reassessment and Replanning.

Within a facility, the essential elements in the process are the patient and his family, members of the health care team who provide and guide the patient's care, and the uniform tool used to assess, plan and evaluate his care. A sample instrument (PACE II) is included in this document as well as instructions and definitions for PACE II application, including translating the assessment into action through care planning and evaluation. It has been carefully developed and tested so that its use will benefit the facility. The PACE instrument can be used as is, or if an instrument already exists, the facility may wish to compare it with PACE for completeness. In any case, the format selected must have provisions for Care Planning and Goal Achievement. The use of common definitions as developed in this manual will avoid confusion and conflicting viewpoints.

AGING AND THE ELDERLY

We need to have an increasing concern for the many interrelated problems of the elderly. There are currently 23 million people over age 65 in the United States—nearly 11 percent of our population. By the year 2,000, there will be 30 million elderly, or 15 percent of our total population. Presently, 4,000 people reach the age of 65 each day, a daily net gain of 1,000 persons. Elderly Americans are becoming the fastest growing segment of our society (1).

Although most of our elderly live in their own houses, apartments, or with relatives, the long-term care facility is becoming a "home" for an increasing number of our elderly and others who have chronic diseases and disabling conditions. A survey in 1975 found that although 78 percent of such patients were 65 years old and over, a least 1 patient in 5 was between 20 and 64 (2).

HEW AND LONG-TERM CARE

With the advent of Medicare and Medicaid in the United States in 1965, professional standards were established and regulations published. Later, the United States Department of Health, Education, and Welfare (HEW) assumed an advocacy role. On June 21, 1974, HEW announced a campaign to upgrade the quality of care provided in the Nation's nursing homes.

Phase I of the campaign was a fact-finding study. The study was designed by agencies involved in long-term care and health care consultants and was implemented by teams of professionals who visited selected long-term care and health care facilities to review the care provided and a sample of patients. One of its most important specific findings was that the survey and certification process focuses on a facility's capability to deliver care, rather than determining if quality care was provided.

A New Focus and Approach

Emphasis on the capability of the institution to provide care was shifted to a new focus—the improvement of the patient's total care within the institution. To sharpen this focus, the goals for long-term care were defined in terms of maintaining or improving the patient's physical and psychosocial status at an optimal level.

It was further concluded that a holistic approach to total patient health care was needed to meet these goals. Originally, a tool (PACE I) and a process were developed so that health personnel could systematically identify needs of patients, plan appropriate care to meet those needs, and evaluate the outcomes of that care.

Following a Feasibility Study conducted in 19 States encompassing all 10 HEW Regions, PACE I was revised to incorporate suggestions from over 500 individuals, including providers, State and Federal personnel, professional and consumer organizations. The revised version is presented as PACE II in this document.

The Patient Care Management (PCM) process is not only a group of structured activities leading to individualized patient care, but is a way of thought. Providers of nursing care will be able to either use the PACE II instrument or their own patient appraisal form. It should be remembered, however, that

whatever instrument is used, patient assessment is only the first part of the process. Care planning and evaluation must be included as well.

This document will explain how the process works with the sample instrument (illustrated with two case studies). Hints for teaching and how the PACE student can test himself with review questions will be found in the PCM Coordinator's Manual Supplement.

The PCM Process

Patient Care Management is a systematic process of patient assessment, care planning, and evaluation of care in both institutional and non-institutional settings. Beginning with patient appraisal, an appropriate assessment instrument guides the user through orderly procedures designed to make it easier to identify a patient's problems and needs. Problem identification, in turn, allows for individualized care-planning. Later the patient is reappraised, the outcomes of previous care evaluated, and new care plans devised, if necessary.

The process is always patient-centered. As the patient's dimensions of care change, his needs are measured, and responded to with repeated care-planning and goal-setting by the health care team. It is important to maintain this pattern in order to reflect the broader orientation of socio-medical needs instead of medical dependency.

An appropriate patient appraisal instrument ensures that background and appraisal data are collected. Based on these data, appropriate care planning is undertaken to meet identified needs. Care evaluation is done periodically to assess the outcomes of care. Based on the evaluation, new goals may need to be set and the care plan revised.

A sample appraisal form with detailed schedules, and Care Planning and Goal Achievement Summary Forms appear in a later section (pages 27-41) of this document. Although references are made to specific portions of the sample instrument, the principles may be applied to the comparable portions of the facility's own documents.

Development of an Appraisal Instrument

The appraisal instrument should be developed so that the health care team can get a comprehensive and objective picture of a patient. In review, the underlying principles that were followed in the development and structuring of PACE and selection of its contents were:

- *Patient-Centered*—All items of information are oriented toward the patient. They describe an individual as he is at the time of the appraisal or reappraisal, rather than describing the setting in which he is located.
- *Multidimensional*—The information obtained is multidimensional. It describes the patient's status from the perspectives of his socio-demographic background, his strengths, weaknesses, impairments, physical functions, social and psychological capacity, and the care he is receiving.
- *Objective*—The items of information are objective, rather than subjective in form. This promotes agreement among persons who observe patients and record their observations by using standardized definitions and terminology.
- *Relevant*—All items are relevant to the ultimate purpose of the process. The completed appraisal becomes the basis for individualizing care planning where the ultimate goal is to optimize the functioning status of the individual.

The sections of the sample instrument (PACE II) and their six major content elements include:

1. *Admission data*—Examines the current setting, the provider of the most previous care, and demographic characteristics of the patient;
2. *Medical data*—Includes current diagnosis for which the patient is receiving care as well as clinical tests and measurements;
3. *Impairment record*—Indicates the physical status of the skin, extremities, sensory/communication system, as the bowel and bladder;
4. *Functional capacity*—Summarizes the patient's capacity to move safely, carry out activities of daily living, eat and maintain his nutrition, and adjust to the social and physical environment;
5. *Patient care data*—Records information on special procedures or services the patient is receiving as well as current medications;
6. *Discharge data*—Provides information on the overall condition of the patient on discharge, his needs, and the next provider of care.

From the rehabilitation viewpoint, the assessment of impairments and functional capacities are the heart of the appraisal.

These data, if retrievable from all long-term care settings, can provide much needed statistical evidence of long-term care needs, met and unmet, and trends in community programming efforts.

The Patient in the PCM Process

The patient is the focus of all management action. He has an active role in his care planning. His dignity and identity—and rights to them—guide all care and management activity.

PATIENT APPRAISAL

A completed appraisal provides a comprehensive profile of the patient. Aside from the basic data it contains, it may be necessary to complete schedules that describe the patient's status in greater detail, e.g., if the patient has a new diagnosis or is nearing discharge. (See Schedules A, B, C, PACE II.)

TIMING THE APPRAISAL

A Care Plan should be completed and implemented for every newly admitted long-term care patient as soon as the initial appraisal is finished, a health team care planning meeting has taken place, and a care plan devised and reviewed with a physician.

THE INITIAL APPRAISAL

Although much patient profile data may be obtained from records soon after admittance to a facility, when the appraisal process has started, it is wise to allow enough time to observe the patient and thus obtain accurate information about his functional and psychosocial status and any impairments he may have. If possible, these sections (especially psychosocial status) should be the last portions to be completed prior to the first care planning session.

The Care Planning Process

From the initial appraisal, the health care team abstracts and records multidimensional information about the patient, defining dysfunctions, impairments, and problems. Working together with the patient and his family, wherever possible, the team identifies and explores these concerns, establishes priorities, sets goals and puts together a care plan designed to help move the patient's function as close to those goals as possible. By determining the present level of function, the team, including the patient and his family, can decide on realistic, feasible, measurable goals designed to either maintain a current level or attain a new level of functioning.

The care plan, including needed services and time-limited goals, is recorded on the Care Planning Form, that eventually becomes part of the patient's permanent record. However, while it is in use, it is kept in such a place to be readily available as a guide to all care givers.

The care planning process may be broken into a number of easily defined steps that the health care team, individually or collectively, can follow:

- Identifying or "flagging" patient problems
- Abstracting major concerns for discussion
- Stating the problems in terms of the patient's functional abilities
- Grouping related conditions for better understanding
- Involving the patient and his family, if possible
- Assigning priorities to problems
- Specifying time-limited, measurable goals
- Specifying actions needed to reach goals
- Identifying who is responsible for each action

TIMING OF THE CARE PLANNING MEETING

The first Care Planning meeting should take place as soon as possible after the appraisal is completed. The Appraiser or Chief Appraiser (See Chapter II, PCM—Application in a Long-Term Care Facility) will schedule the meeting, and will decide which staff professionals will be needed. A Care Planning meeting that coincides with a visit from the attending physician will save telephone calls or additional waiting for confirmation of the Care Plan activities.

THE CARE PLANNING TEAM

The health care team, including staff professionals who are needed, should attend the Care Planning meeting. These will include the Chief Appraiser and Appraiser and the various health team members involved with the individual as revealed by the appraisal. The attending physician, the patient himself, and a member of the patient's family might also attend.

Care Evaluation

Depending on the patient's condition and information on the Goal Achievement Summary, the health care team will determine whether a patient should be reappraised in one week, two weeks, a month's time, or perhaps in three months. It is through reappraisal of the patient's status that the team and the patient, where feasible, are able to evaluate the outcomes of the care previously given by determining if the goals have been met. If goals have not been met, they will find out the reasons. They will also see if the right services have been given to improve function. As with the initial appraisal, concerns will emerge from this process to be abstracted as problems. An important point is that reappraisals will be done on only those items or sections flagged on the previous appraisal instrument that relate to a patient's problem identified.

REPLANNING CARE

From the second appraisal's findings recorded on the instrument, and through evaluation of previous care (reappraisal and determination of goal achievement on Goal Achievement Summary form), the team and the patient decide on a new care plan, perhaps setting new goals, perhaps to approach previously determined goals with different care procedures. The second and subsequent care plans take into consideration the changing situation, but the focus remains the same to improve functioning capacity. Again, the care plan, goals, procedures, and services are recorded in the continuing patient record.

Present and Potential Uses of a PCM System

The goals of a PCM system are to:

- Establish a system that can be maintained by health care personnel within any setting that is current, objective, accurate, complete, and effectively serves personnel in the development of care planning based on patient needs and established goals;
- Provide an internal monitoring tool for the health care setting so that modification of administrative practices and standards of care can be made, if necessary, to improve the quality of care; and
- Provide a base of information for external monitoring through survey and certification, quality assurance and quality improvement activities.

When properly administered, the PCM system can provide:

1. A single, consistent, and current source of patient data identifying: demographic and care need descriptors, including diagnoses, impairments, functional status, etc., and services provided;
2. A data source useful to health care program administrators for resource allocation, determining the cost of care and program planning, etc.;
3. Accessible and measurable data on appropriateness of care as well as its outcomes, to groups or individuals concerned with determination of quality of care;
4. A potential mechanism for instituting a system of appropriate patient placement and continuity of care whether institutional or non-institutional.

In developing an appraisal instrument, a facility or program should also be aware of other uses of the data in addition to patient care management. For example, a Minimum Basic Data Set (MBDS) for long-term care has been developed by the National Center for Health Statistics (NCHS) HEW. A comparative chart has been included in Appendix E for reference purposes.

It is envisioned that PCM systems will have important implications for provision of quality care and in the improvement of general administrative practices in long-term care and other settings. By providing a common data base and uniform terminology, a PCM system can be used by a Professional Standards Review Organization (PSRO), Utilization Review (UR), Medical Review (MR), and Independent Professional Review (IPR). In addition, this usage could result in more appropriate placement of the long-term care patient thus reducing the 30-40 percent of patients now inappropriately placed in long-term care facilities. To accomplish this will require support from health care providers and planner to provide the linkage between various settings for care, both institutional and non-institutional and to assure that services are readily accessible. Identification of problems and gaps in the system will lead to changes that will improve health care delivery to the long-term care patient.

REFERENCES

1. U.S. Department of Commerce, Bureau of the Census, *Demographic Aspects of Aging and the Older Population in the United States* (Current Population Reports: Special Studies Series p-23, No. 59), Washington, D.C., May 1976.
2. U.S. Department of Health, Education, and Welfare, Public Health Service, Office of Nursing Home Affairs, *Long Term Care Facility Improvement Study: Introductory Report*, Washington, D.C. Government Printing Office, 1975, pp. 18-19.

CHAPTER 2

Application of PCM in a Long-Term Care Facility

THE APPRAISAL PROCESS

Appraisal is the foundation for building a care program for each patient. On the accuracy, the depth of inquiry, and the understanding of the patient it reflects, rests the potential for effective planning, providing, evaluating, and replanning care.

During the appraisal process—the recording of observations—information will merge to form a multidimensional profile of a person. By using this initial process, various members of a health care team record the attributes that, carefully interpreted, can describe a unique individual's strengths and weaknesses—physical, emotional, and social.

These items, however, have no significance until they are interpreted by the collective judgment of the health care team. It is a prime purpose of the appraisal to go beyond the individual's problems that precipitated the need for long-term care, and to consider the dimensions of the patient's functioning status.

The initial appraisal, and any reappraisal after giving care, becomes the unique base from which the health care team formulates a specially tailored total care plan.

The PCM process in a facility is used to assess, plan, provide and evaluate care and reassess and replan care for reappraisal of patients on a continuing basis. To manage the system, if possible, one individual should be designated to coordinate and direct the activities in a small institution. In a large institution, different individuals may assume the following roles:

PCM Coordinator may be a nurse administrator, or Director of Nursing Services, or a designated staff person in the long-term care facility who has the primary responsibility for guiding facility personnel in using the facility's appraisal instrument, and for organizing, directing, and facilitating the system. This person is responsible for assuring that personnel understand PCM (Patient Care Management), assisting personnel in learning how to use the facility's assessment instrument, and monitoring the quality of the PCM process within the facility. The PCM Coordinator also serves as liaison between the facility and quality assurance activities, including survey and certification, PSRO, utilization review and the like. In a small facility, the PCM Coordinator may also be the Chief PCM Appraiser.

Chief PCM Appraiser is a staff person, usually a nurse in an administrative or supervisory position, in a long-term care facility who has the lead responsibility for the administration and completion of the facility's appraisal instrument for a group of patients. In a large facility, there may be more than one Chief Appraiser, where one Chief Appraiser may be assigned to each wing of the facility.

PCM Appraiser is a staff person in a long-term care facility who applies various components of the facility's appraisal instrument to a patient at regular intervals (e.g., daily, monthly, or bimonthly). This person is most familiar with the patient and is responsible for working with appropriate members of the health care team from the various health disciplines who contribute to the appraisal.

PROBLEM IDENTIFICATION

Having completed the assessment for a patient, in whatever format the facility has chosen to use, the next step is to identify the problems affecting the patient and the care and supervision required. Even though a patient has an impairment or a problem, its existence may or may not be significant. An impairment becomes identified as a problem, if, in combination with other observations made throughout the appaisal, it is apparent that it contributes to some functional disability and that intervention is necessary and appropriate. Appraisal instruments provide a format for channeling and disciplining observations so that questions are asked that might not have been asked under other procedures.

The Appraiser together with the health care team take the observations made in any one section of the instrument and examine them in the light of observations made in other sections, as to their effects on functioning. The collective judgment of the team will lead to identification of different problems that are pertinent to the individual's health status and how they relate to one another.

The problem should be stated clearly. In many instances, problems observed and recorded during appraisal are related. The patient is a *total* person, and for that reason, no impairment can be viewed or dealt with as if it were an isolated entity. The team must use its expertise to look beyond the separate presenting physical or emotional symptoms. It must begin the grouping of problems.

INVOLVING THE PATIENT AND HIS FAMILY

Patient and family involvement at this point serves these important purposes:

- The planning team learns from them what their goals, needs, and priorities are as they see them.
- The team learns what adjustments must be made in its own planning so that their goals, needs, and priorities are congruent with the team's intentions.
- The team conveys to the patient and his family its ideas and conclusions, and how they relate to their desires.
- The team uncovers areas where education and explanation can serve to hasten the patient's movement to a higher level of functioning.

SETTING PRIORITIES

Once problems have been identified, decisions must be made by the health care team as to which problem is to be attended to first, which can be worked on parallel with others, perhaps using the same modality of care, which may require more definitive information, and which can wait.

To differentiate among problems as to priority, it is convenient to classify them by levels of effect upon the patient:

- Life-threatening conditions that demand immediate intervention or those that have the potential of sudden threat that require constant surveillance;
- Pain and discomfort that are causing such distress to the patient that they preoccupy him and inhibit his functional abilities;
- Quality of life issues that are neither life-threatening, nor necessarily cause pain and discomfort, but that impair the client's sense of well-being and prevent him from functioning freely in his physical, social, or emotional environments.

Since it may not be possible to deal with all problems simultaneously, a life-threatening problem will usually be dealt with first. Depending on their severity, pain and discomfort problems will be dealt with second and quality of life problems last.

SPECIFYING GOALS

A care goal is a written statement of results or outcomes to be achieved in a planned period of time, and in such a way that change can be observed and measured. In other words, goals are a means of naming actions for bridging the gap between the patient's condition now and the status the care team believes he should be able to achieve later.

Goal writing takes practice, thought, and analysis. There are a number of characteristics to look for in the wording of a well-prepared goal; a goal should:

- State a desired outcome. It may be change in *behavior* of the patient, a change in his *clinical findings,* or a change in *knowledge* about him based on new or additional information.
- Be narrow; a given change should be clearly traceable to the factors causing it.
- Contain a criteria for measuring change; usually a numerical value or a quantity will be attached to the outcomes in order to determine if action was successful
- Contain a time element. It clearly says when the new status is to be measured or compared with the old.

In a large number of instances, goals exhibiting these characteristics can follow these models:

Mrs. X Will	(Change)		(What)
From	(How Much)	To	(How Much)
By	(When)		
Staff Will	(Do)		(What)
By	(When)		

In coming to grips with the clear specifications of goals, the most common difficulties lie in stating goals in measurable terms, in clearly describing outcomes, and in assigning time frames. It should also be remembered that there can be goals for the staff as well as the patient, e.g., "by the 15th of next month *teach* Mrs. X proper foot hygiene."

When the goal is of the kind that expresses quality, look for an observable action or behavior that represents, is caused by, or is evidence of a change in that quality. For example, pain, which is entirely subjective, may be inferred from the number of requests for medication; or hostility by the number of angry exchanges with residents and staff. Try always to attach a quantifiable value to the evidence and specify the change desired in numerical terms.

Outcomes will usually be expressed as a new condition or state of being. Try to find expressions that denote a state or condition—"Blood pressure will be 150/90," or a behavior—"Patient will demonstrate understanding," etc.

Time limits must be stated so that they can be identified by a fixed reference. Specify both the beginning time and ending time, when possible, and attach dates or times of day. Say, "By October 15th rather than "By next month" or "In a month from now."

Goals should be clearly stated and be congruent with the individual's medical regimen. Goals should be realistic, attainable and appropriate. Goals set too high cannot be met and may result in feelings of failure; goals set too low will not enable the patient to achieve his optimal level of functioning.

PLANNING CARE

Once goals are established, the team states the specific actions needed to achieve them. Just as the goals are identified in very specific terms, so will the care plan be specific in naming the nature of the service, who is to give it, and its frequency.

The contributions of each team member, each with his or her own particular expertise, are necessary so that there can be an interdisciplinary sharing of

insights and knowledge that leads to multidimensional patient care.

The plan must have three aspects:

- The procedure or activity to meet the goal will be stated;
- The frequency of the procedure or activity will be specified;
- The person responsible for each procedure or activity will be identified.

The plan should be reviewed or discussed with the patient's attending physician to ensure that it is consonant with the medical regimen. A sample care planning form is shown at the end of the next Chapter. In the first column (Problem/Impairment/Dysfunction), problems are initially listed in rank order of priority. A goal is specified for that problem in the second column (Long-Range Goal/Step Toward Goal). The third column (Target Date) should show the date by which it is expected the goal may be achieved.

Care plans are then entered in the fourth column (Plan of Care). Each is numbered to match the goal specified. Each will include what is to be done, the frequency with which the care will be given, and the person responsible for carrying out the procedure or activity.

REAPPRAISAL AND CARE EVALUATION

Change is a constant in patient care, and the PCM process is designed to measure change and to determine whether actions in caring for the patient have been effective.

It is a cyclical process in which assessment and care planning are repeated periodically so that changes in the patient's health status can be monitored. As changes occur in an individual's needs, old goals can be reset or new ones stated in order to meet these changing needs. Care is planned to achieve the revised or new goals. Reappraisal of the patient's status to determine what changes have occurred and if goals have been achieved is the way in which the outcomes of health care can be evaluated.

The evaluative process enables the health care team to determine the quality of care being rendered to patients. The evaluation process involves two steps: 1) a reappraisal at which the time those goals identified in the previous appraisal are reexamined to see which ones were either met or unmet, a notation made of any new problems, and 2) a determination of why some goals may not have been achieved. In sum, evaluation is the assessment of the outcomes of care rendered to the patient.

The flagged sections of the initial appraisal are used as the starting point in reappraising the individual, and the new appraisal is done to see if the care given after initial appraisal accomplished its goals. During reappraisal, the individual's observed response is compared with the expected results specified in the goals. In the second health care team meeting (and following meetings), the PCM Appraiser will have on hand:

- The patient's original appraisal and the reappraisal
- The first detailed Care Plan
- Other pertinent information not yet transferred to the patient's record
- A Goal Achievement Summary

At the meeting, the Appraiser transfers to the Goal Achievement Summary the first goal from the first Care Plan, noting the target date for meeting that goal and the date on which it was appraised. The health care team will then decide the extent of the goal achievement. By using the reappraisal data, a judgment is made as to whether 1) the patient's condition remains unchanged with respect to the goal; or 2) his behavior or condition indicates that the goal has been partially met; or 3) he has totally achieved the goal.

At the same time, a review of the reappraisal, particularly the section on Patient Care (pp. 23-25, PACE II), will reveal whether services planned were actually given or not. The last column for comments provides an opportunity to indicate problems encountered such as "patient had second small stroke," or "family continues to bring in foods not on diet, etc.." Entries explaining reasons for failure to meet goals can be made in the columns.

If a goal has only been partially met or not met at all, the team will decide if goals were unrealistic and reset them, if this is the case. It may be that the care plan needs modification so that the goal will be met. The team will then change the approaches to providing care so that the goal will be achieved. New goals will be set for achievement where the reappraisal data indicate new problems, impairments, or dysfunctions and care planned to meet these goals.

SUMMARY

The translation of data collected by means of the assessment to create an appropriate care plan requires a high degree of sensitivity and awareness on the part of each member of the health care team. In this phase the collective judgment, expertise, and experience of the team is brought to bear on drawing conclusions from data. It is here that facts and observations assessed and recorded on the appraisal must be related to each other.

The solution for one individual will not necessarily be the same as for another, no matter how similar the problem. No two patients are identical nor are the conditions under which their care is planned, or given, identical. Each person's problems are unique and will have numerous variables. Furthermore, care decisions will be weighed in terms of the outcomes of care.

Although care plans will vary from person to person, according to needs, the planning steps are the same, originating from appraisal information. Once the initial appraisal is completed and the patient's problems identified and recorded, the health care team, the patient, and the patient's family prioritize these

problems, set goals, and plan the care appropriate for achieving the goals. Again, only the flagged sections of a previous appraisal need to be reappraised. Subsequent appraisals will use just those pages of PACE II to record evidence of a new problem or a change in the patient's condition.

The final step, evaluation, involves reappraisal which then leads to replanning, thus bringing the entire process full circle. As a patient's condition is stabilized, the frequency of the appraisals will probably decrease. Nevertheless, these steps in the PCM process must be built into efforts that care givers themselves exert to make certain that the system is working properly and that the care provided each patient is effective and efficient.

CHAPTER 3

PACE II Instrument

INTRODUCTION TO THE INSTRUMENT

The following pages present PACE II, a sample instrument for carrying out the Patient Assessment part of PCM. It represents a composite picture of many other assessment instruments in use at the present time. It also reflects the many comments and suggestions presented to HEW by those in the field who know the long-term patient well—the care providers themselves. Others, who saw the potential uses of PACE also contributed, including State agency personnel and representatives of professional and lay organizations. Finally, a number of HEW staff members reviewed the thousands of comments, synthesizing these into a shortened, modified instrument—PACE II.

In addition, a manual of instructions is presented that provides definitions of terms used, as well as scales and the "how to do it" of the instrument.

The use of PACE II is suggested, particularly if the facility or program has no established format for doing patient appraisal. It represents an appraisal in all dimensions—physical, social, psychological and environmental. It also provides a consistency in reporting findings that when feasible can be coded and stored for comparative analysis.

PACE II INSTRUMENT

Sample

ADMISSION DATA

See Instructions pp. 43-47

1. Provider Identification _____
2. Patient Identification Number _____
3. Provider Location _____
4. Provider Type (Specify type) _____
   (See Supplementary Classification of Providers in Appendix A)
5. Date of Latest Admission to Provider ____/____/____
   month day year
6. Date of First Admission to Provider ____/____/____
   month day year
7. Date of Latest Discharge from Provider ____/____/____
   month day year
8. Number of Prior Admission(s) to Provider _____
9. Last Principal Provider (Specify type) _____
   (See Supplementary Classification of Providers)
10. Physician's Prognosis on Admission
    Indicate below the attending physician's prognosis at the time of admission for the client:

☐ **No Change** ☐ **Improvement** ☐ **Deterioration** ☐ **Not Determined** ☐ **Has Discharge Potential (Use Schedule C)**

DEMOGRAPHIC DATA

1. Date of Birth ____/____/____
   month day year
2. Sex: ☐ **Male** ☐ **Female**
3. Race/Ethnicity
   a. Race.
      ☐ **American Indian or Alaskan Native** ☐ **Asian or Pacific Islander** ☐ **Black**
      ☐ **White** ☐ **Not Determined**
   b. Ethnicity
      ☐ **Hispanic Origin** ☐ **Not of Hispanic Origin** ☐ **Not Determined**
4. Current Marital Status
   ☐ **Never Married** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Not Determined**
5. Usual Residence *(Type of residence in which the patient has been residing for the past six months. For clients continuously in an institutional setting for six months or more, the facility will be considered his/her residence.)*
   ☐ **Home/Apartment** ☐ **Rented Room, Commercial Hotel** ☐ **Supportive Housing** ☐ **Institutional Setting**
6. Residence/Location _____
   _____
7. Usual Living Arrangement *(Check all that identify with whom the patient has been living during the past six months.)*
   ☐ **Lived Alone** ☐ **Lived with Spouse** ☐ **Lived with Family** ☐ **Lived with Others**
8. Court Ordered Constraints
   a. Is the client under court ordered care? ☐ **No** ☐ **Yes**
   b. Does he/she have a court appointed guardian? ☐ **No** ☐ **Yes**

DISCHARGE DATA

(To be filled out only at the time of discharge from latest admission to provider.)

1. Discharge Date ____/____/____
   month day year
2. Status on Discharge (Check most applicable)
   ☐ **Improved** ☐ **No Change** ☐ **Deteriorated** ☐ **Deceased**
3. Discharged to: (Specify type) _____
   (See Supplementary Classification of Providers)

MEDICAL DATA

SAMPLE

(Instructions on pp. 47 -52)

Appraisal Number

1 2 3 4 5 6

☐ ☐ ☐ ☐ ☐ ☐

A. Medically Defined Conditions

At the time of admission or first appraisal, record all medical conditions for which the client is actually receiving care by indicating with a check mark the ***single*** *primary diagnosis and* ***all*** *secondary diagnoses as applicable. Write in the specific diagnoses in the last column.*

DIAGNOSTIC CATEGORY	PRIM.	SEC.	SPECIFIC DIAGNOSES
Neoplasms			
Endocrine, Nutritional, Metabolic Diseases, and Immunity Disorders			
Diseases of Blood amd Blood-forming Organs			
Organic Psychotic Conditions			
Other Psychoses			
Neurotic and Personality Disorders			
Mental Retardation, mild			
Mental Retardation, moderate			
Mental Retardation, severe			
Mental Retardation, unspecified level			
Diseases of the Nervous System and Sense Organs			
Stroke, including late effects			
Atherosclerosis			
Diseases of the Circulatory System other than Stroke and Atherosclerosis			
Diseases of the Respiratory System			
Diseases of the Digestive System			
Diseases of the Genitourinary System			
Diseases of the Skin and Subcutaneous Tissue			
Diseases of the Musculoskeletal System and Connective Tissue			
Congenital Anomalies			
Injury and Poisoning			
Symptoms, Signs, and Ill-defined Conditions			
Other diagnosis			
Unknown diagnosis			
No disease			

Schedule A should be used for subsequent appraisals if (1) a previously unrecognized condition is diagnosed and requires care, or (2) a previously recognized condition, that did not require care formerly, becomes active.

B. Medical Status Measurements

On the initial appraisal, record the results of the latest measurements and indicate the date on which the test was made. Any tests done or repeated at a later date should be recorded on Schedule A.

TEST	DATE
1. Height _____ (inches)	_____
2. Weight _____ (pounds)	_____
3. Blood Pressure _____ / _____ *(Systolic) (Diastolic)*	_____
4. Pulse Rate _____ (per minute)	_____
5. Respiratory Rate _____ (per minute)	_____
6. Blood Tests (Type of Test: ☐ Fasting ☐ Postprandial for Blood Sugar below)	
a. Blood Sugar _____(mg. %)	_____
b. Blood Urea Nitrogen _____(mg. %)	_____
c. Hemoglobin _____(Gm.)	_____
d. Hematocrit _____(%)	_____
7. Urine Tests (record as negative, trace, or one or more +'s)	
a. Albumin (Type _____) _____	_____
b. Sugar (Type _____) _____	_____
c. Acetone (Type _____) _____	_____
8. Stool Test for Occult Blood (Type _____) (Record as negative, trace, or one or more +'s) _____	_____
9. Other, specify _____	_____
_____	_____

PATIENT APPRAISAL DATA

SAMPLE
See Instructions pp. 53-54

Appraisal Number
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER ☐☐☐☐☐☐☐☐☐

PACE APPRAISER _____
Name and Discipline

Beginning Date of Appraisal _____

Type of Appraisal ☐ **Admission/Initial** ☐ **Periodic**
☐ **Routine (Annual)** ☐ **Discharge**
☐ **Other (Specify)** _____

1. Present Level of Care (Check appropriate box)
   - ☐ **Skilled Nursing Care**
   - ☐ **Intermediate Care**
   - ☐ **Other (Specify)** _____

2. Present Reimbursement Source(s). Indicate in the space provided whether (P) principal or (S) supplemental; (unless a change has occurred since last appraisal, omit this question).
   - _____ **Medicare (Title XVIII)**
   - _____ **Medicaid (Title XIX)**
   - _____ **Social Services (Title XX)**
   - _____ **V.A.**
   - _____ **Workers' Compensation**
   - _____ **All Other Public Sources**
   - _____ **Blue Cross or Commercial Health Insurance**
   - _____ **Self Pay**
   - _____ **No Charge**
   - _____ **Not Determined**

3. Have any incidents or accidents occurred involving this patient since the last appraisal?
   ☐ **No** ☐ **Yes**
   If yes, give details _____

4. Has there been a significant change in the individual's physical or emotional status since the last appraisal?
   ☐ **No** ☐ **Yes**
   If yes, give details _____

5. Rehabilitation Potential:
   a. Is there a possibility of restoring the indivdual from his/her present physical and/or emotional functional level to a higher level of function? (check appropriate box)
      ☐ **No** ☐ **Yes**
   b. If yes, explain in what functional areas this is possible _____
   c. If no, is there a possibility of preventing deterioration of the present physical and/or emotional state to sustain the individual's current capacities? (check appropriate box)
      ☐ **No** ☐ **Yes**
   d. If yes, specify the functional areas _____
   e. If no, is there a possibility of slowing down the process of deterioration? (check appropriate box)
      ☐ **No** ☐ **Yes**
   f. If yes, specify the functional areas _____

6. If improving, is discharge anticipated within one month?
   ☐ **No** ☐ **Yes**
   If yes, complete Schedule C.

Fill in this section at end of appraisal.
Check appropriate box(es) indicating the professional discipline of persons contributing to this appraisal:

- ☐ **R.N.**
- ☐ **L.P.N.**
- ☐ **Aide/Orderly**
- ☐ **Other, specify** _____
- ☐ **Social Worker**
- ☐ **Physical Therapist**
- ☐ **Occupational Therapist**

PACE Appraiser's signature _____

Date of Completion of Appraisal: ____/____/____
month day year

Appraisal Number

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER ☐☐☐☐☐☐☐☐

A. Skin

1. **Are there any decubitus ulcers present at this appraisal:** ☐ **No** ☐ **Yes**
   If yes, indicate number of sites _____
2. Are there any other skin abnormalities: ☐ **No** ☐ **Yes**

If Item 1 and/or 2 is answered yes, complete Schedule B.

B. Extremities and Trunk

Are there any missing limbs or fracture/dislocation of the hip or other bone: ☐ **No** ☐ **Yes**
If yes, complete the following chart.

EXTREMITY		MISSING LIMBS Date of amputation, and Type: (BE) Below Elbow (AK) Above Knee (AE) Above Elbow (P) Prosthesis (BK) Below Knee	FRACTURED HIP(S) Date of Repair (R) or Prosthesis	OTHER FRACTURES/ DISLOCATIONS Date and Location
UPPER	R			
	L			
LOWER	R			
	L			

C. Sensory/Communication Status (check appropriate box(es)).

1. Vision (with glasses if customarily used)
   ☐ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
   ☐ **b. Moderate loss** ☐ **d. Total blindness**
2. Hearing (with hearing aid if customarily used)
   ☐ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
   ☐ **b. Moderate loss** ☐ **d. Total deafness**
3. Expressive Communication
   Select the one category that best describes the **usual** method used by the patient in conveying information.
   ☐ **a. Speaks and is usually understood** ☐ **d. Uses gestures, grunts, or primitive symbols**
   ☐ **b. Speaks but is understood only with difficulty** ☐ **e. Does not convey needs**
   ☐ **c. Uses structured sign language, symbol board, or writes** ☐ **f. Not determined**
4. Receptive Communication
   Select the one category that best describes the patient's **usual** method of understanding information conveyed by others.
   ☐ **a. Hears and usually understands** ☐ **e. Does not understand**
   ☐ **b. Hears and understands only with difficulty** ☐ **f. Not determined**
   ☐ **c. Depends on lip reading, written materials, or structured sign language**
   ☐ **d. Understands only primitive gestures, facial expressions or simple pictograms and/or recognizes environmental cues**

D. Bowel/Bladder Status

1. Is there bowel incontinence:
   ☐ **No** ☐ **Yes**
   If yes, specify frequency of incidents _____
2. Are there any other bowel problems such as ostomy:
   ☐ **No** ☐ **Yes**
   If yes, specify _____
   If yes, is assistance needed? ☐ **No** ☐ **Yes**
3. Is there bladder incontinence:
   ☐ **No** ☐ **Yes**
   If yes, specify frequency of incidents _____
4. Are there any other bladder problems such as ostomy, indwelling catheter or external device:
   ☐ **No** ☐ **Yes**
   If yes, specify _____
   If yes, is assistance needed? ☐ **No** ☐ **Yes**

Appraisal Number

1	2	3	4	5	6
☐	☐	☐	☐	☐	☐

Note—During any of the specified tests in Section A—Range of Motion and Section B—Strength, Balance, and Coordination, if the client indicates pain on motion, stop that portion of the test immediately. Proceed to another test. If tests in these sections are medically contraindicated, give reasons:

_____ **Date** ___/___/___

_____ **Date** ___/___/___

A. Range of Motion

With patient lying on back on bed, test passive movements of upper and lower extremities for full range of motion. Indicate by check in the chart below if there is restriction and/or disabling condition in any extremity. Specify other observations in the space provided.

PARTS OF THE BODY	RESTRICTED					
	FLEXION A	EXTENSION B	ABDUCTION C	ADDUCTION D	ROTATION E	OTHER OBSERVATIONS F.
1. Right Extremities						
a. Fingers/Thumb						
b. Wrist						
c. Elbow						
d. Shoulder						
e. Ankle						
f. Knee						
g. Hip						
2. Left Extremities						
a. Fingers/Thumb						
b. Wrist						
c. Elbow						
d. Shoulder						
e. Ankle						
f. Knee						
g. Hip						

3. Head and Trunk

With patient sitting unsupported on side of bed, test range of motion of head and trunk. If patient cannot sit unsupported on side of bed for any reason, indicate in the margin that the test was not done. If appropriate, complete test at a later date.

Is there any restriction and/or disabling condition in head or trunk?

☐ **No** ☐ **Yes**

If yes, place a check mark in each applicable box; specify other observations.

	Side to Side	Flexion	Extension	Other Observations
a. Head				
b.Trunk				

Appraisal Number
1 2 3 4 5 6
☐ ☐ ☐ ☐ ☐ ☐

PATIENT ID NUMBER
☐☐☐☐☐☐☐☐

B. Strength, Balance, and Coordination

Note—(1) If the client is bed-bound or chair-bound, complete only those test items that can be performed under those conditions; (2) observe balance and coordination (item 7-8) while testing items 1-6; (3) perform tests and check as applicable; and (4) specify other observations.

1. Patient can dorsiflex foot, and with knee extended, raise leg 10 inches from bed, hold 5 seconds, lower to bed.
   Right Leg: ☐ **Yes** ☐ **No** Left Leg: ☐ **Yes** ☐ **No**
   Other Observations _____
2. Patient can roll from supine to prone in each direction.
   Right to Left: ☐ **Yes** ☐ **No** Left to Right: ☐ **Yes** ☐ **No**
   Other Observations _____
3. Patient can sit up unassisted, swing legs over side of bed and return. ☐ **Yes** ☐ **No**
   Other Observations _____
4. Patient can grasp examiner's hand with normal strength hand grip.
   Right Hand: ☐ **Yes** ☐ **No** Left Hand: ☐ **Yes** ☐ **No**
   Other Observations _____
5. Patient can stand erect having used chair arms for support. ☐ **Yes** ☐ **No**
   Other Observations _____
6. Patient can stand erect unsupported, and with elbows extended, raise both arms above head, hold for 5 seconds.
   ☐ **Yes** ☐ **No**
   Other Observations _____
7. Patient appears to have normal balance when sitting unsupported and standing unsupported.
   Sitting: ☐ **Yes** ☐ **No** Standing: ☐ **Yes** ☐ **No**
   Other Observations _____
8. Patient appears to have normal coordination when moving body parts. ☐ **Yes** ☐ **No**
   Other Observations _____

Review questions in Section A—Range of Motion and Section B—Strength, Balance, and Coordination. If any restrictions and/or impairments are observed, the patient should be seen by a physical or occupational therapist for a more thorough examination.

C. Activities of Daily Living

Indicate the level of performance by placing a check in every column that applies. Think of these functional abilities in relation to the individual's rehabilitation potential when answering parts of question 5 on page 3 of this instrument.

FUNCTION	A NO PROBLEM	B MECHANICAL AID	C HUMAN HELP	D # PERSONS HELPING	E DOES NOT PERFORM	F. REMARKS
1. MOBILITY a. Goes Outside						
b. Walking						
c. Climbing Stairs						
d. Transferring						
e. Wheeling						
2. PERSONAL CARE a. Bathes/Showers						
b. Toileting						
c. Dressing						
d. Grooming						
e. Eating						

DENTAL/ORAL STATUS

SAMPLE

Appraisal Number

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

(Instructions on pp. 96-99

Use a tongue depressor or dental mirror and flashlight to make the examination. Check all boxes that apply and record other problems in space provided to describe condition of the mouth. (Instructions on pp. 96-97)

Natural Teeth	None	1-10	11+	Satisfactory	Decay	Fracture	Pain	Loose	Unclean
Dentures Complete or Partial	None	Upper / Uses	Lower / Uses	Satisfactory	Broken	Missing Teeth	Uncomfortable	Loose	Unclean
Oral Soft Tissues	Normal	Gums Inflamed	Dry Mouth	Ulcer, Sore, Lump, or Other Lesion					
				Tongue	Under Tongue	Lips	Palate	Cheeks	Gums

Other Dental/Oral Problems _____

NUTRITIONAL STATUS

1. Is there a special diet prescribed?
   ☐ **No** ☐ **Yes**
   If yes, check appropriate diet(s) listed below.
   ☐ **a. Mechanical Soft Diet**
   ☐ **b. Bland-Low Residue Diet**
   ☐ **c. Diabetic Diet**
   ☐ **d. Calorie Restricted Diet**
   Specify calorie level _____
   ☐ **e. Sodium Restricted Diet**
   ☐ **f. Fat Modified Diet**
   ☐ **g. Other, specify** _____
2. Is there an intake problem?
   ☐ **No** ☐ **Yes**
   If yes, check those that apply below.
   ☐ **a. Solid Food Problem (Specify)** _____
   ☐ **b. Fluid Intake Problem (Specify)** _____
3. Is there an output problem?
   ☐ **No** ☐ **Yes**
   If yes, check those that apply below.
   ☐ **a. Constipation**
   ☐ **b. Diarrhea**
   ☐ **c. Fluid Retention**
   ☐ **d. Other (Specify)** _____
4. Are there food likes or dislikes?
   ☐ **No** ☐ **Yes**
   If yes, complete the folowing:
   a. Are they recorded? ☐ **Yes** ☐ **No**
   b. Are they carried out? ☐ **Yes** ☐ **No**
5. Are there cultural/religious constraints? ☐ **No** ☐ **Yes**
   If yes, complete the folowing:
   a. Are they recorded? ☐ **Yes** ☐ **No**
   b. Are they carried out? ☐ **Yes** ☐ **No**
6. Are supplementary nourishments given, e.g., a high protein commercial preparation ☐ **No** ☐ **Yes**
   If yes, specify _____
7. What is the usual dining location? _____
8. Weight (this appraisal) _____
9. Has there been a recent weight change? ☐ **No** ☐ **Yes**
   If yes, specify whether gain or loss and how much. _____

PSYCHOSOCIAL FACTORS

SAMPLE
See Instructions pp. 99-103).

Appraisal Number -
1 2 3 4 5 6
☐ ☐ ☐ ☐ ☐ ☐

PATIENT ID NUMBER
☐☐☐☐☐☐☐☐

A. Patient's Adjustment to Care Plan
Note: The following items may not be applicable to a newly admitted patient. If care plan has not been developed on first appraisal, omit this item and write N.A. in the margin. Complete on subsequent appraisals when care plan has been developed

ITEM	PATIENT		FAMILY/SURROGATE	
	YES	NO	YES	NO
1. Involved in care planning				
2. Cooperated actively—with positive attitude and enthusiasm				
3. Cooperated passively—made no inputs, but carried out plan				
4. Found fault with some items in the care plan but followed plan				
5. Found fault with Items in the care plan and refused to cooperate				
6. Was provided with an educational experience explaining the rationale for the treatment and care plan				

B. Patient's Social Interaction and Adjustments to the Facility
Describe the pattern of behavior for the individual by checking the appropriate column for each item.

ITEM	USUALLY	OCCASIONALLY	NEVER
1. Is oriented to the time and space of his/her living environment.			
2. Cooperates with rules and regulations.			
3. Asserts self and makes needs known.			
4. Participates in self-directed activities.			
5. Personalizes living space.			
6. Personalizes apparel.			
7. Participates in structured activity program.			
8. Eats in dining room (if physically capable).			
9. Spends free time outside his/her own room.			
10. Has visitors from outside the facility.			
11. Visits others outside the facility.			
12. Has outside contacts, i.e., letters, calls, etc..			
13. Talks about events that go on outside the facility.			
14. Engages in conversation with staff.			
15. Engages in conversation with fellow patients.			
16. Relates in an appropriate adult manner to fellow patients.			
17. Relates in an appropriate adult manner to staff.			

C. Behavioral Problems

Describe the usual manner of behavior for the individual by checking the appropriate column for each item (1-15). Indicate in Column A those behaviors which have not been exhibited; and in Column B those that have been exhibited by the patient and specify by checking the appropriate box which of those behaviors interfere with the functional capacity, require special care, and/or supervision.

BEHAVIORS	(A) DOES NOT EXHIBIT	(B) EXHIBITS	
		DOES NOT INTERFERE	INTERFERES
1. Apprehensive			
2. Withdrawn			
3. Hyperactive			
4. Abusive to self			
5. Disruptive			
6. Hostile			
7. Abusive to others			
8. Wanders			
9. Forgetful			
10. Confused			
11. Delusional			
12. Hallucinates			
13. Emotionally labile			
14. Depressed			
15. Inappropriate behavior, other specify _____			

If the individual's adjustment to the care plan, his/her social interaction and adjustment to the facility, or behavioral characteristics affect his/her functional capacity or necessitate additional care and/or supervision, then consideration should be given to having the patient examined by a psychiatrically oriented professional such as a psychiatric or other qualified social worker, psychiatric nurse, clinical psychologist or psychiatrist.

Appraisal Number

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

A. Special Procedures

For each procedure listed below, check those given at the time of this appraisal, and indicate the frequency performed and by whom.

	PROCEDURE	FREQUENCY	BY WHOM
General Nursing Care	☐ 1. Preventive Skin Care		
	☐ 2. Decubitus Care		
	☐ 3. Sterile Protective Dressings		
	☐ 4. Turning Schedule or Repositioning		
	☐ 5. Oxygen Rx		
	☐ 6. Inhalation IPPB		
	☐ 7. Suctioning		
	☐ 8. Irrigation—Bladder		
	☐ 9. Irrigation—Other than Bladder		
	☐ 10. Ostomy Care		
	☐ 11. Enemas		
	☐ 12. Hydrotherapy (e.g., Whirlpool Baths, Soaks)		
	☐ 13. Maintenance Ambulation		
	☐ 14. Restraints		
	☐ 15. Other (Specify)		
Rehabilitation/Restorative	☐ 16. Speech Pathology/Audiology		
	☐ 17. Bowel Training		
	☐ 18. Bladder Training		
	☐ 19. Passive Exercises		
	☐ 20. Transfer Skills Training		
	☐ 21. Active Exercises		
	☐ 22. Resistive Weight Lifting Exercises		
	☐ 23. Gait Training		
	☐ 24. Prosthetic Training		
	☐ 25. Other (Specify)		
Teaching	☐ 26. Diet Instruction		
	☐ 27. Ostomy Care (Type)		
	☐ 28. Foot Care		
	☐ 29. Self Injection		
	☐ 30. Other (Specify)		
Psychosocial	☐ 31. Self-directed Activities		
	☐ 32. Group Activities		
	☐ 33. Religious Activities		
	☐ 34. Reality Orientation Therapy		
	☐ 35. Remotivation Therapy		
	☐ 36. Behavior Modification Therapy		
	☐ 37. Social Counseling		
	☐ 38. Other (Specify)		

B. Professional Visits

Was a professional visit by the attending physician or a consultant made to the patient/resident during this appraisal period.

☐ **No** ☐ **Yes**

If yes, indicate below the date(s) on which such visits were made.

	DATE(S)
☐ 1. Attending Physician (M.D. or D.O.)	
☐ 2. Consultant Physician (M.D. or D.O.)	
☐ 3. Dentist	
☐ 4. Optometrist or Ophthalmologist	
☐ 5. Speech Pathologist/Audiologist	
☐ 6. Psychologist	
☐ 7. Podiatrist	
☐ 8. Other (Specify) _____	

PATIENT CARE (Cont'd)

C. Medications

In the following chart, identify by name, the medication in each category actually given on the day chosen for review. Record the unit dosage (e.g., 65 mg., ii tab., 10 units, etc.), the number of times the drug was given (e.g., 1, 3, 6, etc.), and the route of administration (e.g., p.o., (H), etc.). See Appendix B. Drug Classification Guide for explanation of categories.

CATEGORY	NAME	DOSAGE	# OF TIMES	ROUTE OF ADMIN.
1. Adrenal Cortical Hormones, etc.				
2. Analgesics				
3. Antacids				
4. Anticoagulants				
5. Anticonvulsants				
6. Antidepressants				
7. Antidiarrheals				
8. Antihistamines				
9. Antihypertensives				
10. Anti-infectives				
11. Anti-Parkinsonism Agents				
12. Bronchodilators				
13. Cardiac Drugs				
14. Cathartics				
15. Diuretics				
16. Electrolyte/Fluid Replacements				
17. Estrogens/Androgens				
18. Expectorants/Cough Preparations				
19. EENT Preparations				
20. Insulin/Antidiabetic Agents				
21. Narcotic Analgesics				
22. Sedatives/Hypnotics				
23. Skin/Mucous Membranes				
24. Spasmolytics/Antispasmodics				
25. Stimulants				
26. Thyroid Replacements				
27. Tranquilizers				
28. Vasodilating Agents				
29. Vitamins/Minerals				
30. Other				
31. Additional Drugs/Category:				
(Use Categories 1-29 above)				

Total # of Medications: _____
Total # Given by IM or IV or Subcutaneous route: _____
Total # Given that require additional supervision or care: _____
Date of Day Chosen for Appraisal Review ____/____/____
month day year

Since last appraisal, were there any manisfestations of undesired side effects or toxicity due to medications including allergic reaction, interactions, drug dependence, etc.

☐ **No** ☐ **Yes**

If yes, specify type, time of occurrence, and steps taken to alleviate the problem _____

When was the last time medications were reviewed? Date: ____/____/____
month day year

By whom were medications reviewed? (Check all that apply)

☐ **Pharmacist** ☐ **Physician** ☐ **Nurse**

☐ **Other, specify** _____

SCHEDULE A

MEDICAL DATA

SAMPLE

Appraisal Number

1 2 3 4 5 - 6

☐ ☐ ☐ ☐ ☐ ☐

PATIENT ID NUMBER

☐☐☐☐☐☐☐☐

1. Medically Defined Conditions

Indicate below any new or reactive medically defined conditions not identified at time of admission or first appraisal. Follow approved medical record keeping system of your institution and State, such as the use of ICDA-9-CM Classification Codes. Give date of onset of condition and include as appropriate in next care plan.

CLASS.	DIAGNOSIS	DATE OF ONSET	COMMENTS

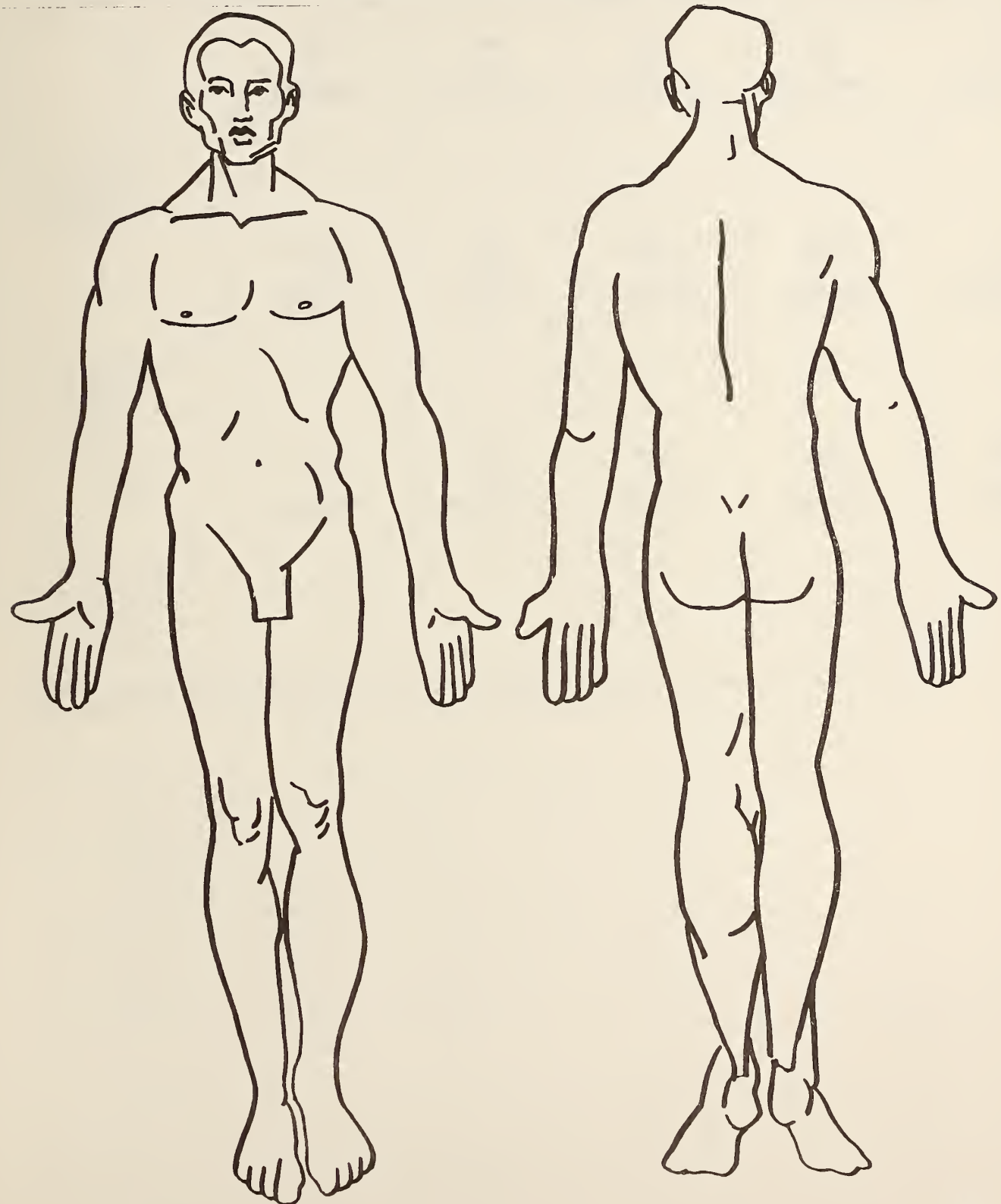
2. Medical Status Measurements (Record new additional test findings after first appraisal).

TEST	DATE/READING	DATE/READING	DATE/READING	DATE/READING

SCHEDULE B

DETAILS OF DECUBITUS ULCERS AND OTHER SKIN CONDITIONS OR PROBLEMS

For each site of an abnormal skin condition identified: 1) circle the location on the anatomical figure below, 2) number the site, and 3) enter the date of onset of the skin abnormality next to the site circled. Be sure the site number corresponds to the chart in this Schedule B where the details of the skin problem should be described.



SCHEDULE B (Cont'd)

SKIN PROBLEM

SAMPLE

Appraisal Number

1 2 3 4 5 6

☐ ☐ ☐ ☐ ☐ ☐

PATIENT ID NUMBER

☐☐☐☐☐☐☐☐☐

For each site of a decubitus ulcer or abnormality identified, complete one section of the chart as follows: (1) record the diameter in cms.; (2) the depth as (s) shallow or (d) deep; and (3) the status as (c) clean or (p) purulent.

1. Site	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**
1) Diameter					
2) Depth					
3) Status					
2. Site	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**
1) Diameter					
2) Depth					
3) Status					
3. Site	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**
1) Diameter					
2) Depth					
3) Status					

Provide detail of any other skin abnormality including type such as dryness, redness, inflammation or infection, rash, or injury (abrasion, laceration, etc.) site and date of onset.

SCHEDULE C

Appraisal Number

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER ☐☐☐☐☐☐☐☐

Once the physician has determined that the patient has Discharge Potential, Schedule C should be used for Discharge Planning. This Schedule has space at the end for a brief summary. Date all entries.

DETAILS OF READINESS FOR DISCHARGE

1. Ability to Carry out IADLs

Indicate the level of performance for the following Instrumental Activities of Daily Living (IADLs) by placing a check in every column that applies. In addition, summarize other observations and specific problems in completing each task.

IADL	A. NO PROBLEM	B. HUMAN HELP	C. # PERSONS HELPING	D. DOES NOT PERFORM	E. REMARKS
1. Using the telephone					
2. Handling money					
3. Securing personal items					
4. Tidying up*					
5. Preparing simple meals					

2. Availability of Caretaker (Check most applicable)

☐ Patient/resident needs no care
Patient/resident needs care and;
- ☐ Family/others able and will provide
- ☐ Family/others available but not able to provide
- ☐ Family/others not available

3. Residence (Check most applicable)

☐ Living space available and adequate
☐ Living space available but not adequate
☐ Living space not available

*Includes housekeeping chores, such as making a bed, claaning, picking up objects from tha floor, and vacuuming carpets.

PATIENT ID NUMBER

☐☐☐☐☐☐☐☐

A. PATIENT STATUS INFORMATION

4. The patient/resident performs all Activities of Daily Living (ADL) without assistance or assistance will be provided by others:

☐ yes ☐ no (Refer to Physical Function, Part C Chart)

If answer to item 1 is no, what ADLs does patient/resident need assistance with? (Specify) _____

_____

_____

What plans are being made to provide the needed assistance? (Specify) _____

_____

5. The patient/resident has no service needs or needs will be met by others: ☐ yes ☐ no

If answer to item 2 is no, what service needs are required? (Specify) _____

_____

_____

What plans are being made to provide the needed services? (Specify) _____

_____

6. The patient/resident performs all independent Activities of Daily Living without assistance or assistance will be provided by others:

☐ yes ☐ no (Refer to IADL Chart)

If no, what plans are being made to provide the needed assistance? (Specify) _____

_____

7. The patient/resident has funds (personal and/or other) available and can be used:

☐ yes ☐ no

If no, what funds are needed? (Specify) _____

_____

_____

What plans are being made to obtain needed funds? (Specify) _____

_____

_____

8. With whom were discharge plans discussed? (Check all that apply)

☐ Patient ☐ Family ☐ Physician ☐ Social Worker

☐ Other person (Specify) _____

9. With which, if any, were discharge plans discussed?

Community Resource Agencies (Specify) _____

_____

Other Resource Agencies (Specify) _____

_____

10. Discharge summary (include diagnoses, summary of course of prior treatment, and rehabilitation potential)

_____

_____

_____

_____

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CARE PLANNING AND GOAL ACHIEVEMENT SUMMARY

A sample care planning form and goal achievement summary are found on the next pages. The *Care Plan* is organized as follows: In the first column Problem/ Impairment/ Dysfunction (P/I/D), problems are listed and numbered in rank order of priority. A goal is specified for that problem in the second column (Long-Range Goal/Step Toward Goal). The third column (Target Date) should show the date by which it is expected the goal may be achieved. Care plans are then entered in the fourth column (Plan of Care). Each is numbered to match the goal specified. Each will include what is to be done, the frequency with which the care will be given, and the person responsible for carrying out the procedures or activity.

The *Goal Achievement Summary* is a discussion of the progress that the patient has made in accomplishing the goals set up for him by the appraisal team. *The Appraiser is to transfer to the Goal Achievement Summary the first goal from the first Care Plan, noting the target date for meeting that goal and the date on which it was appraised. The reappraisal data allows the appraiser to make a judgment as to whether: 1) the patient's condition remains unchanged with respect to the goal, 2) or his behavior or condition indicates that the goal has been partially met, or 3) he has totally achieved the goal. Following this reappraisal, the appraiser must indicate whether services planned were actually given or not, and the date if a problem has been resolved. The last column for comments provides an opportunity to mention problems encountered, the reasons for failure to meet goals, or the need for an altered goal statement.

* To simplify the writing style and facilitate the use of this book, the patient (resident or client) will frequently be given a masculine pronoun, whereas the appraiser, usually a nurse, be feminine.

Patient's Name _____ Date Care Planning Session ____/____/____ Session No. _____
Month Day Year

Patient's ID Number ☐☐☐☐☐☐☐☐ Date Appraisal Completed ____/____/____ Team Present _____
Month Day Year

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM

Date Next Care Planning Session ____/____/____
Month Day Year

Patient's Name _____ Patient's ID Number _____ Summary No. _____

Date Care Planning Session _____

GOAL ACHIEVEMENT SUMMARY

P.I.D. #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		

Manual of Instructions

ADMISSION DATA

General Information

Admission Data (Questions (Q) 1-10), identify the patient's social and demographic characteristics as he appears within the long-term care system

Sources of Information
Patient's Medical Record
Transfer or interagency referral form
Business Office records
Patient and/or Family

Instructions

Complete the items in this section only once.
Record all dates in PACE, in this manner

_____

mo. day year

ADMISSION DATA

1. Provider Identification	The unique number within a reporting system assigned to the provider where the patient is currently residing and/or receiving care.
2. Patient Identification	A unique number assigned to each patient within a long-term care setting that distinguishes the patient's records from all others in that long-term care setting.
3. Provider Location	Use acceptable and appropriate geocode
4. Provider Type	Definitions: See Supplementary Classification of Providers. Appendix A
5. Date of Latest Admission to Provider	Month, day, and year for this admission.
6. Date of First Admission to Provider	Date on which the patient was first admitted to this facility regardless of time. (If this is first admission, give same date as in Item #5. this Section, mark #7 and #8 as N.A.)
7. Date of Latest Discharge from Provider	Date on which the patient was last discharged from this provider before present admission.
8. Number of Prior Admission(s) to Provider	The number of times the patient has been admitted to this provider within the past five years, excluding the latest admission.
9. Last Principal Provider	The type of provider that was principally

	responsible for health and related services to the patient prior to present admission or commencement of services. Use Supplementary Classification of Providers.
10. Physician's Prognosis on Admission	Indicate what the physician anticipated as the course for the patient. If "guarded", record as deterioration.

DEMOGRAPHIC DATA

General Information

Demographic Data (Q. 1-8), identify the patient's unique personal statistics as he appears within the long-term care population.

Sources of Information
Patient's Medical Record
Transfer or interagency referral form
Business Office records
Patient and/or Family

Instructions

This section needs to be completed only once, unless there is a change in an item such as marital status. If this occurs, e.g., from married to widowed, record such information; enter in the margin the date on which the change in status occurred.

Demographic Data

1. Date of Birth	Patient's birth date, designated by month, day, and year.
2. Sex	Self-explanatory
3. Race/Ethnicity	Racial and ethnic background that best describes the patient
a. Race	
1) American Indian or Alaskan Native	A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.
2) Asian or Pacific Islander	A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.
3) Black	A person having origins in any of the black racial groups of Africa.
4) White	A person having origins in any of the original peoples of Europe, North Africa, or the Middle East.

b. Ethnicity	
1) Hispanic origin	A person of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.
2) Not of Hispanic origin	Any other than of Hispanic origin.
4. Current Marital Status	The status of the patient relative to the civil rite or legal status of marriage. Marital status is considered to be that reported by the patient.
1) Never married	Include those never married or those whose marriage was annulled.
2) Married	Includes common-law marriages.
3) Widowed	Include those whose spouse has passed away and who has not remarried.
4) Divorced	Include those legally divorced and who has not remarried.
5) Separated	Include those with legal separations, those living apart with intentions of obtaining a divorce, and other persons permanently or temporarily separated because of marital discord.
5. Usual Residence	The type of residence in which the patient has been residing for the past six months. For patients living continuously in an institutional setting for six months or more, the facility will be considered the residence.
1) Home/Apartment	A private residence, single or multiple dwelling, owned or rented by the patient or by another individual with whom the patient lives. Includes rented rooms with private kitchen for preparing meals.
2) Rented Room, Commercial Hotel	Rooms with or without board, residential clubs, hotel, YMCA rooms, etc. Rented rooms may include a private bath, but the inclusion of a private kitchen for preparing meals would constitute an apartment in the category of home/apartment.
3) Supportive Housing	A living arrangement that, at minimum, provides formally organized checking services and assistance in arranging for health care; or, is specially equipped architecturally for the handicapped or aged, but does not employ health or personal care personnel. Includes certain retirement centers for the

	well aged, specially designed apartment buildings for the aged or handicapped, communal homes or apartments for mentally retarded adults, etc.
4) Institutional Setting	Includes Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Intermediate Care Facility for the Mentally Retarded (ICF MR), and hospital (General, Psychiatric, Geriatric, or Specialty).
6. Residence Location	The location of the place identified above using acceptable and appropriate geocode.
7. Usual Living Arrangement	Identifies those with whom the patient has been residing during the past six months
8. Court-Ordered Constraints	Whether the patient is under court ordered care or has a court appointed guardian. In cases where there is court ordered care or a court appointed guardian, a document to this effect will be in the record.
a. Court-Ordered Care	Care received by a child or adult on either an inpatient or outpatient basis as the result of a court order.
b. Court-Appointed Guardian	A guardian is an individual or corporation appointed by the court to manage some or all of the affairs of an adult who has been found by the court to be unable to manage himself and his affairs with ordinary prudence or a minor when the parent is not available or has been found unfit. This includes limited and plenary guardians.

DISCHARGE DATA

General Information

Discharge Data, (Q 1-3), records the patient's status on discharge from the facility

Source of Information	
Patient's Medical Record	PACE Appaisal Form and Schedules particularly Schedule C: Readiness for discharge
Business Office Records	

Instructions

This section of the instrument is not a part of the initial appraisal. It is to be completed immediately upon the patient's discharge from the facility.

DISCHARGE DATA

1. Date of Discharge	Self Explanatory

2. Status on Discharge	Give the physician's opinion of the patient's status at the time of discharge as compared to that at the time of the latest admission to the provider.
3. Discharged to:	Identify the type of provider that is to be principally responsible for health and related services to the patient following discharges from this provider. Use Appendix A—Supplementary Classification of Providers.

MEDICAL DATA

General Information

A. **Medically Defined Conditions**—Identify the disease or condition precipitating the patient's admission to or necessitating continued stay in the facility, as well as other conditions requiring prolonged care.

Sources of Information

Patient's Medical Record	Transfer or interagency referral form
Physician's Order Sheet	Hospital Discharge Summary

Instructions

Enter checkmarks opposite the applicable diagnostic categories. Enter only one in the primary diagnosis column and as many as are applicable in the secondary diagnosis column.

For each checkmark, in each category, record the specific disease entity by name, under Specific Diagnosis.

Note that Schedule A should be used for subsequent appraisals only if (1) a previously unrecognized condition is diagnosed and requires care, or (2) a previously recognized condition that did not formerly require care becomes active.

DIAGNOSTIC CATEGORY

Primary (PRIM.) Diagnosis	The major medically defined condition or disease associated with the principal disability, handicap, or impairment for which the individual has been admitted or which necessitates continued stay for long-term care. In the absence of disabilities, handicaps, and impairments, the primary diagnosis is the illness for which the individual is receiving long-term care at the time of the appraisal.
Secondary (SEC.) Diagnosis	Any other medically defined condition(s) or illness(es) for which the individual requires care at the time of the appraisal.
Medically Defined Conditions	Code numbers are those of the U.S. clinical modification of the 9th edition of the International Classification of Diseases (ICD-9-CM).

Neoplasms	Neoplasms (ICD-9-CM 140-239) (e.g., cancer, malignancy, benign tumors, leukemia, Hodgkins disease, carcinoma)
Endocrine, Nutritional, Metabolic Diseases, and Immunity Disorders	Endocrine, nutritional and metabolic diseases and immunity disorders (ICD-9-CM 240-279) (e.g., gout, obesity, phenylketonuria, acidosis, cystic fibrosis, diabetes, malnutrition, vitamin deficiency)
Diseases of the blood and blood-forming Organs	Blood and blood forming organs (ICD-9-CM 280-289) (e.g., anemia, polycythemia, purpura) (Low levels of hemoglobin or other laboratory test results may not be construed as anemia without a medical diagnosis.)
Organic Psychotic Conditions	Organic psychotic conditions (ICD-9-CM 290-294) (e.g., senile dementia, psychotic organic brain syndrome, drug and alcohol-related organic psychoses)
Other Psychoses,	Other psychoses (ICD-9-CM 295-299) (e.g., schizophrenia, manic and depressive disorders, autism)
Neurotic and Personality Disorders	Neurotic disorders, personality disorders and other nonpsychotic mental disorders (ICD-9-CM 300-316) e.g., Alcohol dependence syndrome (303) Drug dependence (304) Specific nonpsychotic mental disorders following organic brain damage (301)
Mental Retardation, mild	(ICD-9-CM 317)
Mental Retardation, moderate	(ICD-9-CM 318.0)
Mental Retardation, severe	(ICD-9-CM 318.1)
Mental Retardation, profound	(ICD-9-CM 318.2)
Mental Retardation, level unspecified*	(ICD-9-CM 319)
Diseases of the Nervous System and Sense Organs	ICD-9-CM (320-389) Inflammatory disease of central nervous system (320-326) Hereditary and familial diseases of nervous system (330-333) Other diseases of central nervous system (340-349) Disorders of the peripheral nervous system (350-359)

*Also see Herbert J. Grossman, ed. *Manual on Terminology in Classification in Mental Retardation.* Washington, DC: American Association on Mental Deficiency, 1977.

	Disorders of the eye and adnexa (360-379) e.g., Blindness and low vision (369) Diseases of the ear and mastoid process (380-389)
Stroke, including late effects	(ICD-9-CM-431, 432, 434, 436, and 438)
Atherosclerosis	(ICD-9-CM-440)
Diseases of the Circulatory System other than Stroke and Atherosclerosis excluding ICD-9-CM (431, 432, 434, 436, 438 and 440)	(ICD-9-CM 390-459) Chronic rheumatic heart disease (393-398) Hypertensive disease (401-405) Ischemic heart disease (410-414) e.g., Coronary insufficiency with angina pectoris (411.9) Angina pectoris (413) Other forms of heart disease (420-429) e.g., Cardiac dysrhythmias (427) Disease of arteries, arterioles, and capillaries (440-448) Disease of veins and lymphatics and other disease of circulatory system (451-459)
Diseases of the Respiratory System	(ICD-9-CM 460-519) Acute respiratory infections (460-466) Other diseases of upper respiratory tract (470-478) Pneumonia and influenza (480-487) Chronic obstructive pulmonary disease and allied conditions (490-496) e.g., Bronchitis (490) Emphysema (491) Asthma (493) Other disease of respiratory system (510-519) e.g., Pleurisy (511) Pulmonary congestion and hypostasis (514)
Diseases of the Digestive System	(ICD-9-CM 520-579) Disease of oral cavity, salivary glands, and jaws (520-529) Disease of esophagus, stomach, and duodenum (530-537) Appendicitis (540-543) Hernia of abdominal cavity (550-553) Noninfective enteritis and colitis (555-558) Other diseases of intestine and peritoneum (560-569) Other diseases of digestive system (570-579)
Diseases of the Genitourinary System	(ICD-9-CM 580-629) Nephritis, nephrotic syndrome and nephrosis (580-589)

	Other diseases of the urinary system (590-599) e.g., Infections of kidney (590) Cystitis (595) Urethritis (597) Other disorders of urethra and urinary tract (599) e.g., Urinary tract infection
Diseases of the Skin and Subcutaneous Tissue (e.g., carbuncle, boil, abscess, pilonidal cyst, psoriasis, dermatitis, rash, eczema)	(ICD-9-CM 680-709) Infections of skin and subcutaneous tissue (680-686) Other inflammatory conditions of skin and subcutaneous tissue (690-698) Other diseases of skin and subcutaneous tissue (700-709) Decubitus ulcer (707.0) e.g., Pressure ulcer, Plaster ulcer Excludes: Gangrene (785.4) Specific infections under "Infections and Parasitic Diseases" (001-136) Varicose ulcer (454)
Diseases of the Musculoskeletal system and Connective Tissue	(ICD-9-CM 710-739) Arthropathies and related disorders (710-719) e.g., Arthropathy associated with infections (711) Crystal arthropathies (717) Arthropathy associated with other disorders (713) Rheumatoid arthritis and other inflammatory polyarthropathies (714) Other and unspecified arthropathies (716) Rheumatism, excluding the back (725-729) Osteopathies, chondropathies and acquired musculoskeletal deformities (730-739)
Congenital anomalies	(ICD-9-CM 740-759)
Injury and Poisoning	(ICD-9-CM 800-999) A hip fracture includes subcapital, midcervical, and pertrochanteric fractures of the femur. Special interest is in the fracture of the femur – neck or shaft, and/or fracture of pelvis or acetabulum – involving the following two subcategories: Fractures (800-829)

Fracture of neck and trunk (805-809)
Fracture of pelvis (808)
e.g., fracture of ilium, innominate bone, ischium or pelvic rim
Fracture of lower limb (820-829)
Fracture of neck of femur (820)
Other (Specify) (830-999)

Symptoms, Signs and Ill-defined Conditions

(ICD-9-CM 780-799)
Symptoms (780-789)
e.g., Symptoms involving cardiovascular system (785)
Symptoms involving digestive system (787)
e.g., Flatulence, eructation and gas pain (787.3)
Symptoms involving urinary system (788)
e.g., Incontinence of urine (788.3)
Other Symptoms involving abdomen and pelvis (789)
Senility without mention of Psychosis (797)

Other Diagnosis

INFECTIONS AND PARASITIC DISEASES (ICD-9-CM 001-139)
Intestinal infections diseases (001-009)
Other salmonella infections (005)
Other food poisoning (bacteria) (005)
Intestinal infections due to other organisms (008)
Ill-defined intestinal infections (009)
Other (Specify) (010-139)
COMPLICATIONS OF PREGNANCY, CHILDBIRTH, AND THE PUERPERIUM (ICD-9-CM 630-676)
CONGENITAL ANOMALIES. (ICD-9-CM 740-759)
CERTAIN CONDITIONS ORIGINATING IN THE PERINATAL PERIOD. (ICD-9-CM 760-799)

Unknown diagnosis

(ICD-9-CM 799.9)

No disease

(ICD-9-CM 799.9)

General Information

B. Medical Status Measurements, (Q1-8), are the recorded results of specific test and measurements that reflect the patient's present physical condition.

Sources of Information

Direct Observation
Patient's Medical Record
Transfer or interagency referral form
Hospital Discharge Summary

Instructions

On first appraisal, record the most recently taken measurement.

Do not record any information obtained more than six months prior to appraisal date.

Record the date on which a measurement is done, or a test initiated, in the margin opposite the specific test; likewise, record the date when the laboratory test results were returned.

If additional tests are done, or the above tests are repeated at a later date, record the information in *Schedule A. Laboratory Tests.*

Note that irregularities or wide variations in the patient's Blood Pressure, Pulse Rate or Respiratory Rate, should be flagged in the instrument and recorded in the Patient's Medical Record.

MEDICAL STATUS MEASUREMENTS

1. Height	Height in inches. If the patient's height includes fractions of an inch, record the next higher measurement.
2. Weight	Weight in pounds. If the patient's weight includes fractions of a pound, record the next higher measurement. If the patient is weighed frequently and the weights are fairly stable, the most recent weight is recorded.
3. Blood Pressure	Latest reading of Blood Pressure. If frequent BPs are taken and they are fairly stable, the most recent reading is recorded. Irregular or wide variations in the readings should be noted in the patient's medical record.
4. Pulse Rate	Record the number of beats per minute. Unless otherwise noted, it is assumed the reading is the radial pulse. If frequent pulse rates are taken, and they are fairly stable, the most recent rate is recorded. Irregularities or wide variations in the pulse rate should be noted in the patient's medical record.
5. Respiratory Rate	Record the number of respirations per minute. If frequent readings are taken and they are fairly stable, the most recent reading is recorded. Irregularities or wide variations in the respiratory rate should be noted in the patient's medical record.
6. Blood Tests	
a. Blood Sugar	Record in mg%, e.g., 70, 275, etc., and circle whether fasting or postprandial
b. Blood Urea Nitrogen	Record result in mg%, e.g., 75, 136
c. Hemoglobin	Record result in grams, e.g., 10.5
d. Hematocrit	Record result in percent, e.g., 41
7. Urine Tests	Self Explanatory
a. Albumin	Record as negative, trace, or one to four +'s
b. Sugar	
c. Acetone	
8. Stool Test for Occult Blood	Record as negative, trace, or one to four +'s

PATIENT APPRAISAL DATA

General Information

Identifies management data, including which staff professional in the facility is responsible for the appraisal. This section also records the patient's present level of care, and the reimbursement source for that care.

Sources of Information
Business Office records
Patient's medical records

Instructions

Under Type of Appraisal, check if this is an initial PACE appraisal, Periodic or Routine/Annual, or Discharge, whichever is considered applicable as of the Beginning Date of Appraisal.

Item 2 requires the identification of *all* reimbursement sources. Mark the principal source "P" and each supplemental source "S".

Items 3-5 are to be answered only on appraisals after the admission/initial one.

Item 6 requires the completion of Schedule C if discharge of patient is anticipated within one month of the date of the appraisal.

PACE Appraiser:	The person responsible for completing the appraisal form either directly from observation or indirectly by obtaining information from others.
Beginning Date of Appraisal	Date on which collection of Numbered Appraisal Data Begins—i.e., Impairments, functional status, etc.

TYPE OF APPRAISAL

☐ Admission/Initial	Self-Explanatory
☐ Periodic	Patient appraisals scheduled at regular intervals as stipulated in the care plan or required by law, regulation, or facility policy.
☐ Routine (Annual)	Appraisal carried out on all or sample of patients in facility for purposes such as annual data collection required by State, special national study, etc.
☐ Discharge	Final appraisal including discharge planning
☐ Other, (Specify)	Any other not described above
1. Present Level of care	
☐ Skilled Nursing Care	As defined by Titles XVIII and XIX
☐ Intermediate Care	As defined by Title XIX
2. Present Reimbursement Source(s)	
Medicare (Title XVIII)	Reimbursement for services under Title XVIII of the Social Security Act
Medicaid (Title XIX)	Reimbursement for services under Title XIX of the Social Security Act

Social Services (Title XX)	Reimbursement for social services under Title XX of the Social Security Act
Veterans Administration	Reimbursement for services by Veterans Administration
Workers Compensation	Reimbursement for services provided to the patient for a work related injury or illness
All Other Public Sources	Includes reimbursement by Champus, State and local welfare, services by State-supported facilities
Blue Cross or Commercial Health Insurance	Reimbursement for services under a private health insurance policy
Self Pay	Includes personal and family sources, life care contract, Social Security and other retirement funds, income maintenance sources such as Supplemental Security Income, and other funds over which the individual or his guardian has control and which are not specifically ear-marked for health care
No Charge	Services are free or are paid for from charity, special research or teaching sources
3. Accidents or Incidents	Evidence in records or other special report that patient has had a fall, been burned, or developed a transmittable infectious disease, etc.
4. Significant Change in Status	Evidence in record or other special report that there has been an unexpected deterioration or improvement in patient's physical, social, or psychological well-being since last appraisal
5. Overall Direction of Patient's Progress	As indicated by attending physician
6. Readiness for Discharge	Self-explanatory. Provide summary and details in Schedule C.

IMPAIRMENTS

General Information

Impairment items (Sections A-E) record the patient's deviation from physical norms for body senses and body parts.

Sources of Information

Patient	Transfer or interagency referral form
Patient's Medical Record	Hospital Discharge Summary

Instructions

Note that, if any decubitus ulcers or skin abnormalities are present at appraisal, *Schedule B: Details of Decubitus Ulcers and Other Skin Conditions,* is to be completed by the nurse appraiser.

Impairments	Conditions in which a special sense is diminished, or a part of the body is diminished in function or is missing. Also see definition applied to specific condition, function, or organ. For example, decubitus ulcers are recorded as impairments of the skin.
A. Skin	
1. Decubitus Ulcer	A break in the skin or an ulcer caused by prolonged pressure which has interrupted the circulation to an affected part of the body.
2. Skin abnormalities	Those conditions of the skin, such as redness, irritation, rashes, dryness and blanching, that are possible precursors to decubitus ulcers.
B. Extremities and Trunk	

General Information

The Extremities and Trunk block identifies impaired areas of the body which may be contributing to functional limitations. In planning care, this block should be considered along with the sections on Range of Motion, Strength, Balance, and Coordination, and Activities of Daily Living.

Instructions

Missing Limbs. Complete for a limb missing, i.e., right or left arm, right or left leg, in part or in whole. If no limb is missing, place a dash in each of the four spaces of the column, and go on to Fractured Hip(s).

Specify any missing limb by putting a check in the appropriate box. At each check, write in the date(s) of amputation.

Write in the appropriate abbreviation, BE, AE, BK, AK, for amputation site.

If the patient has a prosthesis, place a P to the right of the amputation site abbreviation.

Fractured Hip(s). Complete for (1) a hip fracture presently requiring care, or (2) a functional impairment in terms of Range of Motion, or Strength, Balance, and Coordination, because of a past or present hip fracture. If there is no hip fracture, place a dash opposite *Lower R* and *Lower L*, and go to the column entitled *Other Fractures/Dislocations.*

Specify a hip fracture by placing a checkmark in the appropriate space. At each checkmark, write in the date of Fracture, preceded by the letter F, and write in the date of Repair, preceded by the letter R.

For each hip fracture, specify if the patient has a prosthesis by writing in P. If the patient has no prosthesis, place a dash to the right of the date of Repair.

Other Fractures/Dislocations. Complete for past or present fractures and/or dislocations of any body part causing any functional limitation or incapacity at the time of appraisal. If there are no such fractures or dislocations, place a dash in each space provided.

Specify fractures and/or dislocations of *all* body parts (head, trunk, or extremities) by utilizing the spaces marked Upper, Lower, Upper R, Upper L.

For each fracture and/or dislocation, (1) write in *F* for Fracture, *D* for Dislocation, *FD* to designate both; (2) specify exact location of the body part involved; (3) write in the date of each occurrence.

B. Extremities and Trunk

Missing Limbs	The absence in part or in whole of an extremity caused by congenital malformation, trauma or surgical procedure.
Type of Amputation	
BE	*B*elow the *E*lbow
AE	*A*bove the *E*lbow
BK	*B*elow the *K*nee
AK	*A*bove the *K*nee
Prosthesis (P)	The artificial replacement of a missing limb, or in the case of the hip, replacement of the head of the femur, the hip socket or the total hip (both femoral head and socket).
Hip Prosthesis	(See Prosthesis above)
Fracture	A broken Bone
Dislocations	Displacement or temporary removal of a bone from its normal position in the joint.

C. Sensory/Communication Status

1. Vision	Ability to see, with correction by spectacles if customarily worn, and in good light.
Normal or minimum loss	Sees adequately in most situations (can see newsprint, public notices, television, medications, etc.).
Moderate loss	*Cannot* see newsprint or public notices or television or medications or toiletries but can see obstacles in path, and the surrounding layout; usually *can* count fingers at arm's length.
Severe loss	*Cannot* find way around without feeling or using cane; cannot locate objects without hearing or touching them; *can* tell light from dark.
Total Blindness	No vision at all, i.e., cannot tell light from dark.
2. Hearing	Ability to hear, with hearing aid if customarily worn.
Normal or minimum loss	Hears adequately in most situations (can carry on an unrestricted conversation or otherwise responds appropriately to being addressed without speaker raising voice or altering normal pace and style of diction in groups as well as one-to-one; TV or radio; addressed from behind; etc.).
Moderate loss	Hears adequately only in special situations (i.e., one-to-one, with firm, clear diction, raised volume of radio, etc.)

Severe loss	Hears with difficulty even in special situations (i.e, conversation restricted, many misunderstanding, or frequently fails to respond, etc.).
Total deafness	No hearing at all useful for communication.

Instructions

For Questions 3 and 4, place a checkmark next to the one category that best describes the usual pattern of the patient's method of communication.

3. Expressive Communication	Process of making known to others, by any means, one's desires and/or necessities for physical, mental and social comforts.
a. Speaks, usually understood	Self-explanatory
b. Speaks, but understood with difficulty	Self-explanatory
c. Uses structured sign language, symbol board, or writes	Patient communicates by using structured sign language, e.g., American Sign Language for the Deaf, and/or other formalized nonverbal means.
d. Uses gestures, grunts or primitive symbols	Self-explanatory
e. Does not convey needs	Patient conveys no information.
4. Receptive Communication	Process of receiving and understanding information conveyed by others. Understanding conveyed by behavior.
a. Hears and usually understands	Usually understands oral communication.
b. Hears and understands only with difficulty	Has limited comprehension of oral communication.
c. Depends on lip reading, written materials, or structured sign language	Behavior shows understanding of lip reading, structured sign language, e.g., American Sign Language for the Deaf, and/or other formalized nonverbal means.
d. Recognizes environmental cues	Understands only primitive gestures, facial expressions or simple pictograms and/or recognizes environmental cues; for example, that setting the table means a meal is forthcoming, that he is to swallow a proffered oral medication, that getting into a coat precedes going out, etc.
e. Does not understand	No behavior exhibited in response to any communication.

D. Bowel/Bladder Status

Instructions

Place a checkmark in each space provided, in response to the "yes" or "no" questions.

Specify the frequency of accidents (bowel and/or bladder incontinence) as *X* number of times per day, per week, etc., in the appropriate space. Show *X/day* or *X/wk.*, etc.

Bowel/Bladder Status

1. Bowel Incontinence	Accidental or involuntary evacuations of feces from the bowels.
2. Ostomy	A surgical procedure that establishes an artificial anus by opening into the colon (colostomy) or ileum (ileostomy).
Assistance needed	Another person or persons must care for the patient's ostomy—Stoma and skin cleansing, dressings, application or appliance, irrigations, etc.
Assistance not needed	The client cares for his/her ostomy completely.
3. Bladder Incontinence	Accidental or involuntary emptying or loss of urine from the bladder.
4. Ostomy	A surgical procedure that establishes an external opening into the ureter(s).
Indwelling Catheter	A hollow cylinder passed through the urethra into the bladder and retained there to keep the bladder drained of urine.
Assistance needed	Another person or persons cares for the patient's urinary device.
Assistance not needed	Patient completely cares for urinary device, e.g., changes the catheter or external device, irrigates as needed and empties and replaces the receptacle.
External device	A Urosheath or urinary drainage apparatus with a receptable attached to collect urine.

PHYSICAL FUNCTION

General Information

Physical Function (Section A-C), describes the patient's characteristic pattern of physical performance.

Source of Information
Patient
Patient's Medical Record
Nursing Notes
Direct Observation

A. *Range of motion* (Q. 1-3), consists of tests specifically designed to bring the patient's extremities through the motions necessary to determine the functional capacity of the nerves, muscles, ligaments and tendons, in whole or in part.

Special Notes

1. The Range of Motion (ROM) examination will be performed as a *screening examination* by a nurse.

2. *Pain on motion:* If the patient indicates pain on *any* motion, stop that portion of the test immediately, but proceed to the next portion. For example, if there is pain elicited by flexing

the right wrist, stop that motion, but proceed to checking flexion and extension of the right elbow. Make a notation in the column titled *Other Observations*, opposite the name of the body part in which the pain occurred.

3. *Medical Contraindications:* The tests should be completed only if there are no medical contraindications. If *no test* in Sections A and/or B can be completed, the appraiser should indicate on the PACE form:

   1. "Section A medically contraindicated".
   2. Date of this appraisal.
   3. Reason(s) why the test(s) are contraindicated.

If any *portion* of any test is medically contraindicated, put an X in the appropriate spaces or section, write in opposite that space or section, "Medically contraindicated" and complete by following instructions 2, and 3 above.

4. *Other Observations:* While the tests are in progress, the appraiser should note whether or not the patient exhibits or verbalizes pain, dizziness, breathlessness, or fatigue, and specify in the column "Other Observations".

The appraiser should observe the patient for disabling conditions such as paresis, tremor contractures, "frozen" or flail joints, and specify in *Other Observations.*

5. *Prosthesis:* If the patient has a prosthesis for any part of any extremity, do not assess that extremity. Place a dash in the appropriate space(s) and note in *Other Observations* that the patient has a prosthesis. (The patient's use of a prosthesis will be evaluated in other portions of the instrument, such as in *Section C, Activities of Daily Living.)*

6. *Further Assessment*

On initial appraisal, if any impairment, restriction, or deviation from normal is observed during any *Range of Motion* test, or *Strength, Balance, and Coordination* test, the patient should be assessed by a qualified physical or occupational therapist, for immediate input into the patient care planning process.

Definitions

Disabling Condition	A physical or mental impairment which interferes with function
Restriction	That which limits or restricts the use of a part of the body, or the normal range of motion of a joint
Other Observations	Include pain, swelling, instability or immobility of the joint or tremor or contracture of the extremity
Pain and swelling	Any inflammatory process in the joint as evidenced by pain and redness or swelling in the joint area. It may or may not limit mobility
Instability	Inability of a joint to maintain functional motion and/or position when stress or pressure is applied
Immobility	Total restriction in the movement of a joint, i.e., a "frozen" joint

Contracture	An abnormal condition of an extremity whereby shortening of the tendons or ligaments supporting a joint results in high resistance to stretching of the muscle
Tremor	An involuntary movement of a part or parts of the body resulting from alternate contractions of opposing muscles.
Dizziness	A condition in which the patient loses the power of balancing himself and has a false sensation as to his own movements or to those of surrounding objects
Breathlessness	Involuntary panting or gasping for breath
Fatigue	Self-Explanatory
Paresis	A slight or partial paralysis
Flail Joints	The joint has abnormal mobility due to separation, displacement, or destruction of the bony structures, and/or muscle paralysis

Instructions

The range of motion exercises begin with an examination of the upper right extremity and then continue with the lower right extremity. Following completion of the right side, the examiner should follow the same procedures beginning with the upper left extremity and ending with the lower left extremity. Enter the results obtained in the following range of motion, strength, balance, and coordination tests on pages 6 and 7 of the PACE II form.

The tests in A and B for *passive* motion should be carried out in one continuous movement using the descriptive steps and accompanying illustrations as references. For section A and B, patient should be lying on back in bed (See Figure 1) Indicate any restricted motion observed during any test by placing a checkmark in the appropriate space(s) on the assessment form. If no restricted motion is observed, place a dash in the appropriate space(s).

Note: During any part of the specified tests in Section A—Range of Motion, and Section B—Strength, Balance, and Coordination, if the patient (client) indicates pain on motion, stop that portion of the test immediately. Proceed to another test.

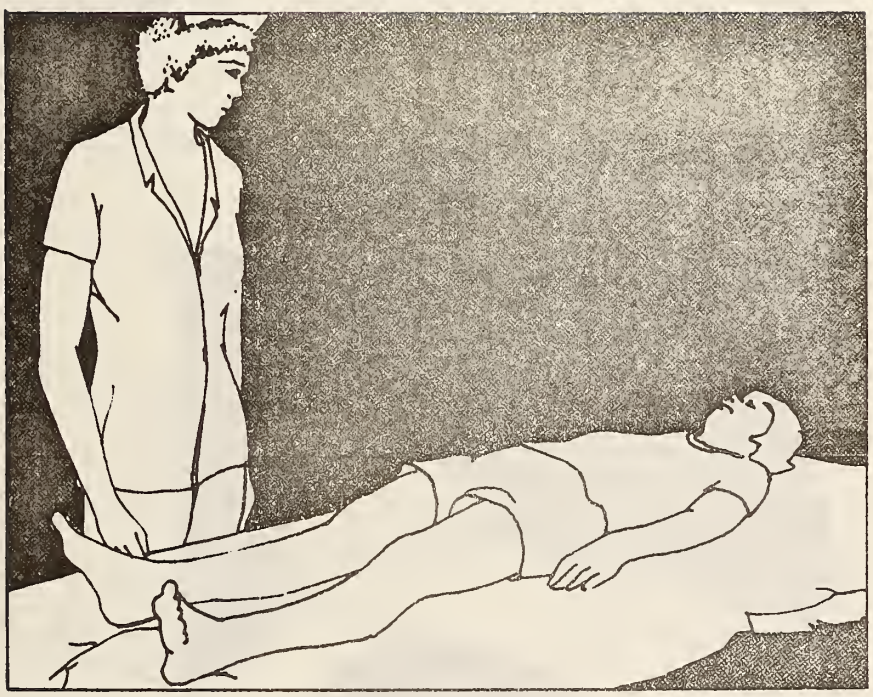

Figure 1
Beginning Position for Range of Motion Tests

A. Upper Extremities

Step 1. Grasp the patient's hand and flex the wrist, fingers, and thumb (hand, finger, thumb flexion).

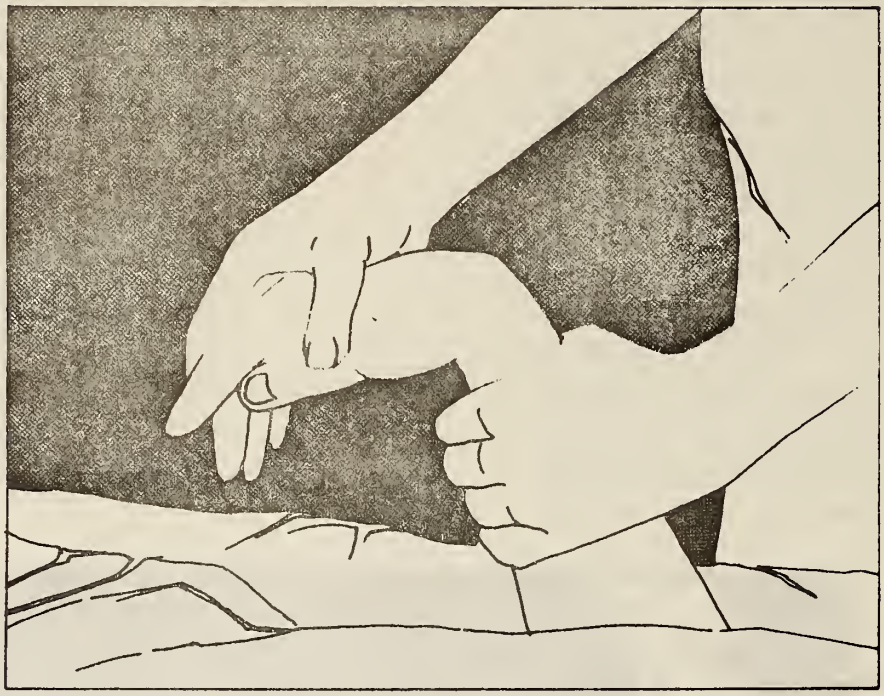

Figure 2
Wrist Flexion

Figure 3
Finger and Thumb Flexion

Step 2. Flex the elbow

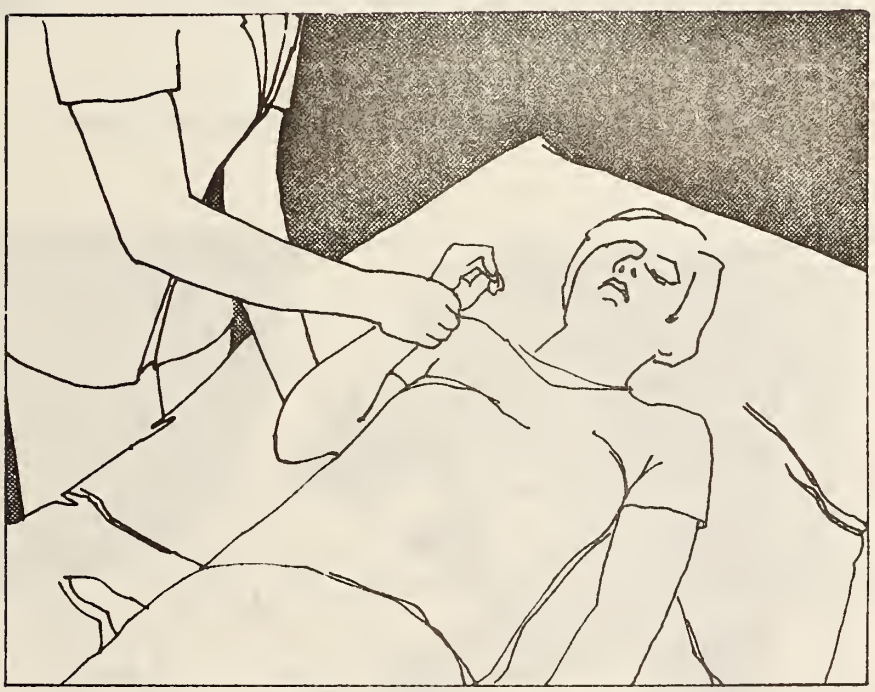

Figure 4
Elbow Flexion

Step 3. Flex the shoulder until the inner surface of the forearm rests on the brow of the head. Move the upper arm as close as possible to the surface of the bed (shoulder flexion). Make sure the palm of the patient's hand faces the head.

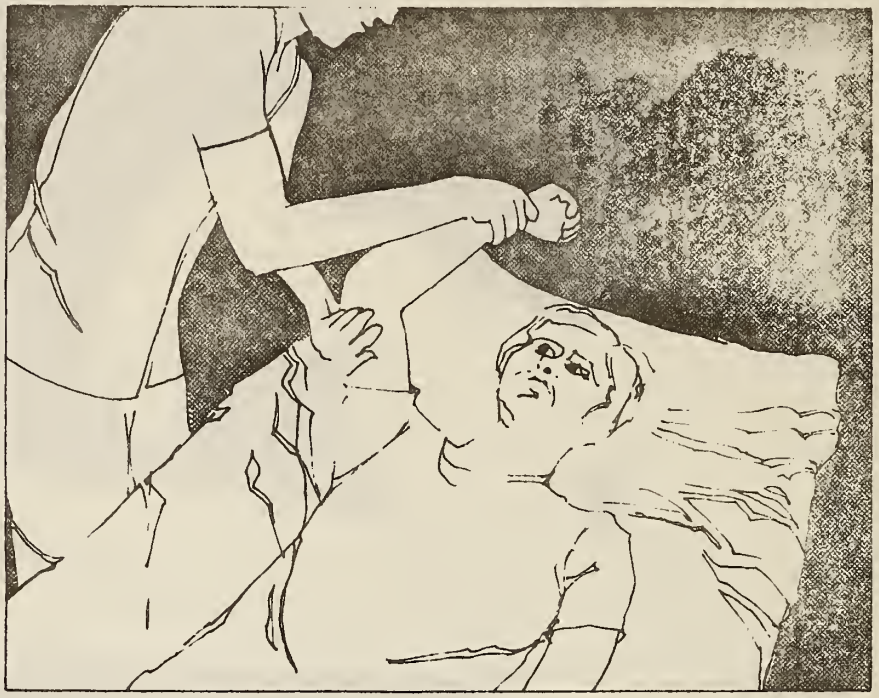

Figure 5
Shoulder Flexion—Intermediate Stage

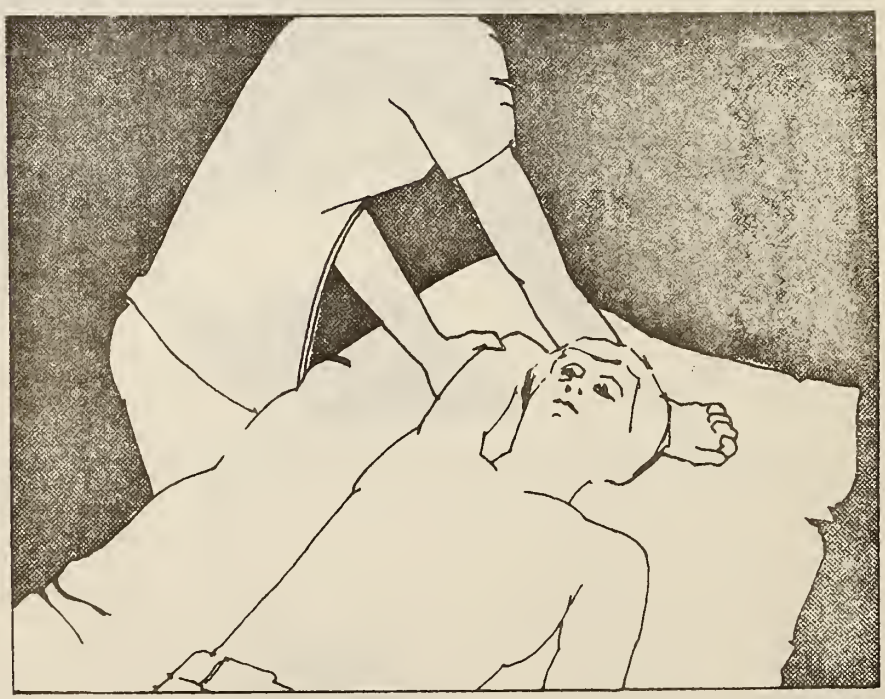

Figure 6
Shoulder Flexion—Completed Motion

Step 4. Extend the wrist, fingers, and thumb (hand, finger, thumb extension).

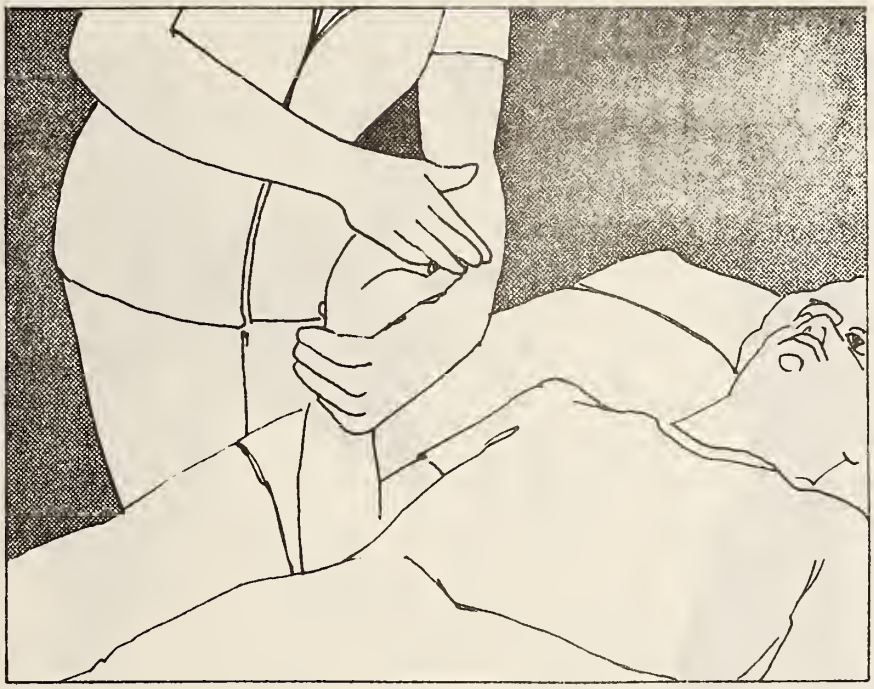

Figure 7
Wrist Extension

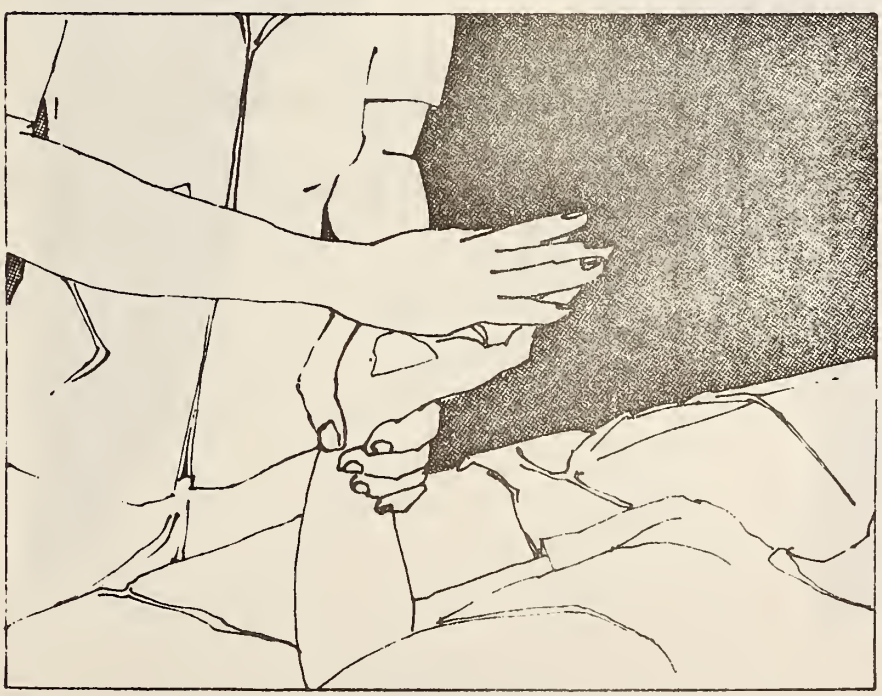

Figure 8
Finger and Thumb Extension

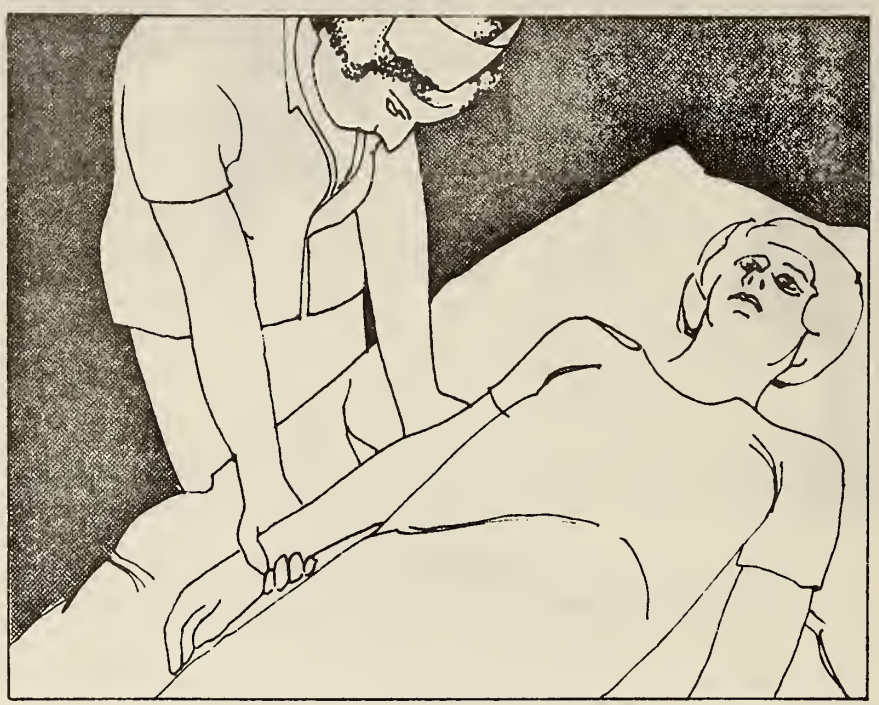

Figure 9
Shoulder and Elbow Extension

Step 5. Fully extend the elbow so that the forearm rests on the bed (shoulder and elbow extension).

Step 6. Move the arm parallel to the bed surface out and away from patient's midline (shoulder abduction). Make sure the palm of the patient's hand faces his head.

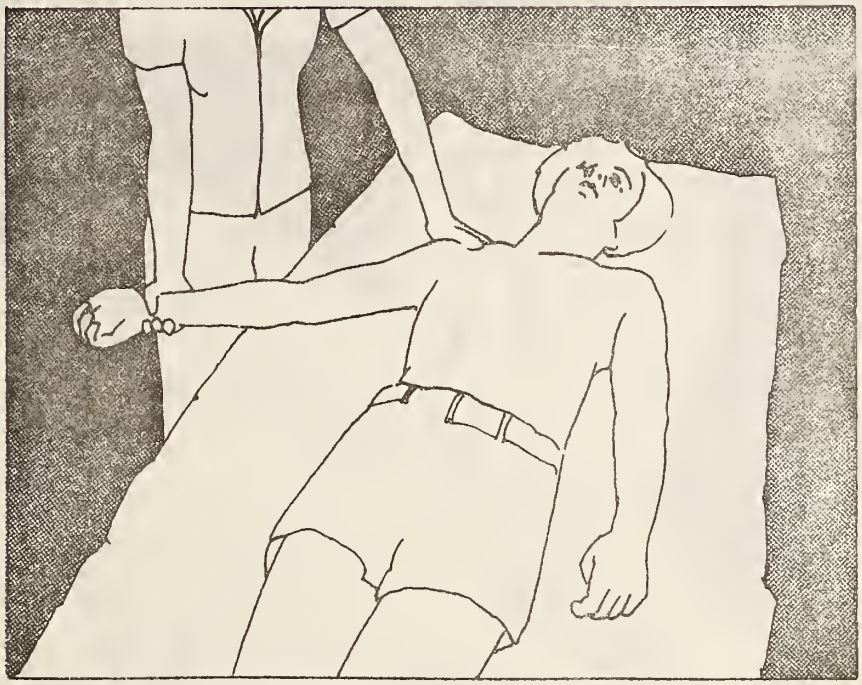

Figure 10
Mid-way Shoulder Abduction

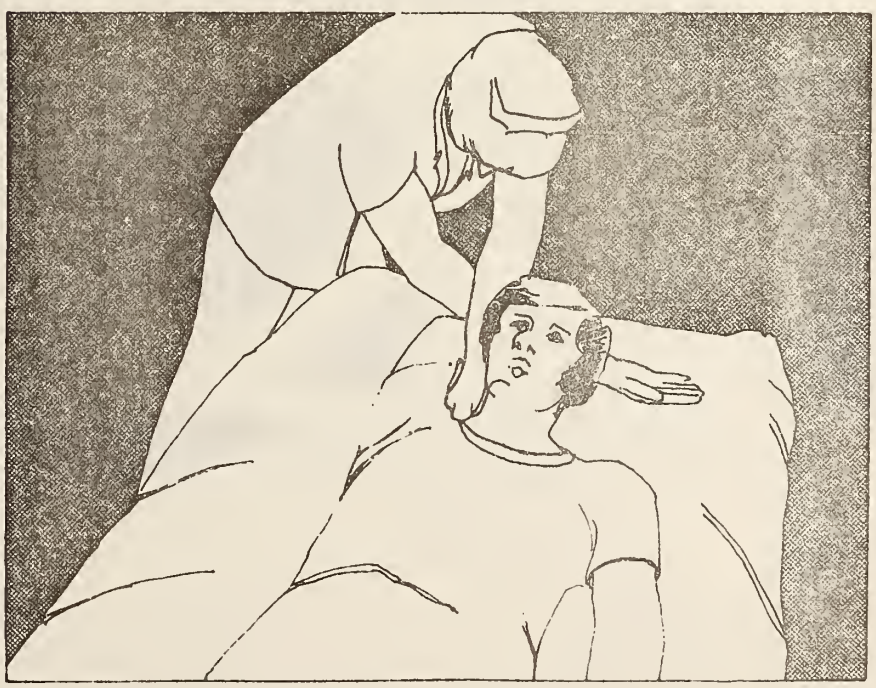

Figure 11
Completed Shoulder Abduction

Step 7. Reverse the motion, returning the arm to the patient's side (shoulder adduction).

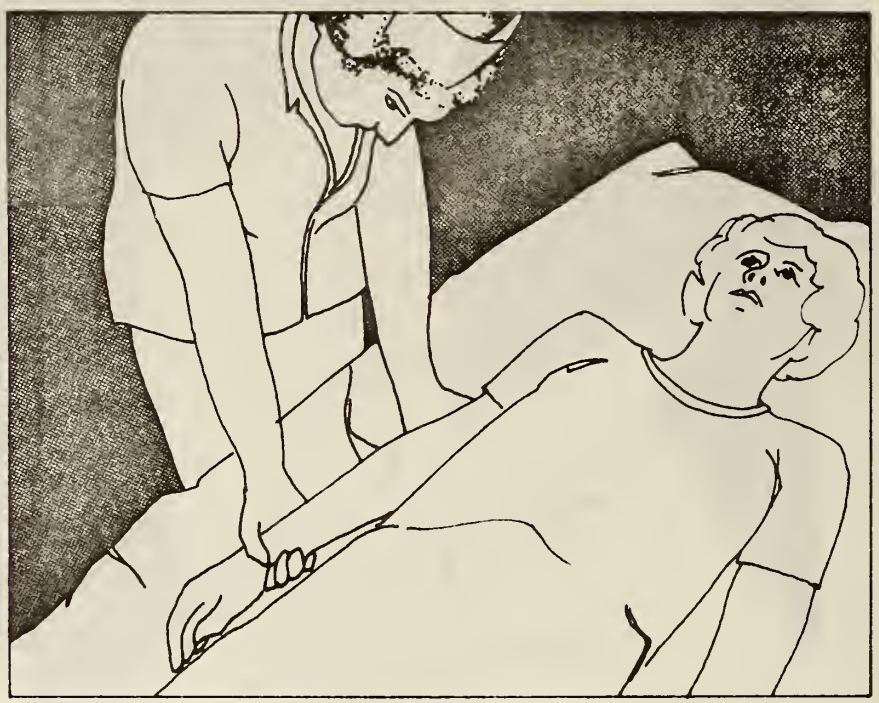

Figure 12
Shoulder Adduction

Step 8. Straighten shoulder away from body (90°) keeping arm parallel to the bed, flex the elbow upright 90°. Rotate the shoulder by taking the patient's hand toward the bed surface at the head of the bed (external rotation of shoulder).

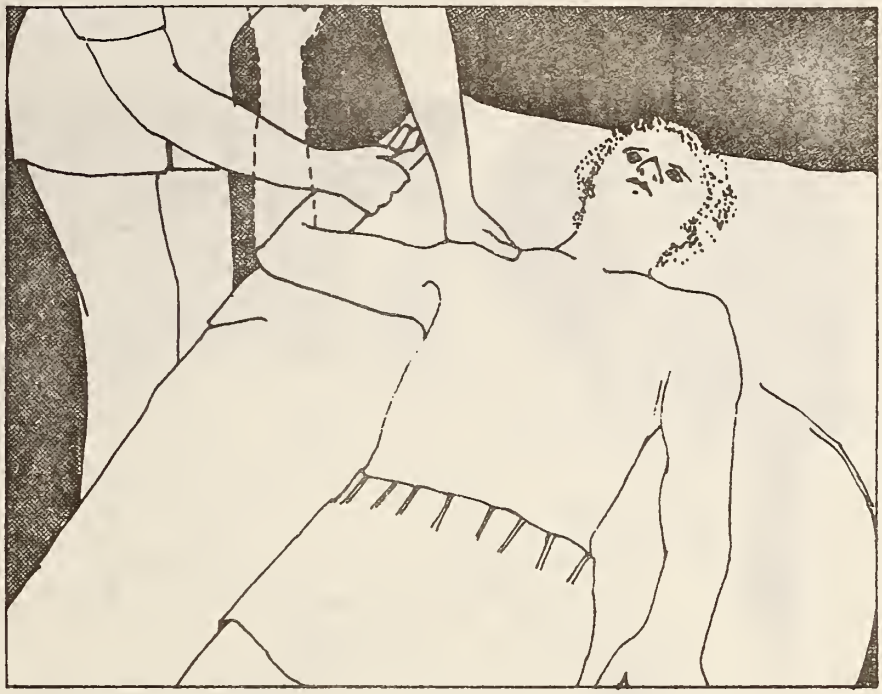

Figure 13
External Rotation of Shoulder

Step 9. Now, rotate the shoulder by taking the patient's hand toward the bed surface at the foot of the bed (internal rotation of shoulder).

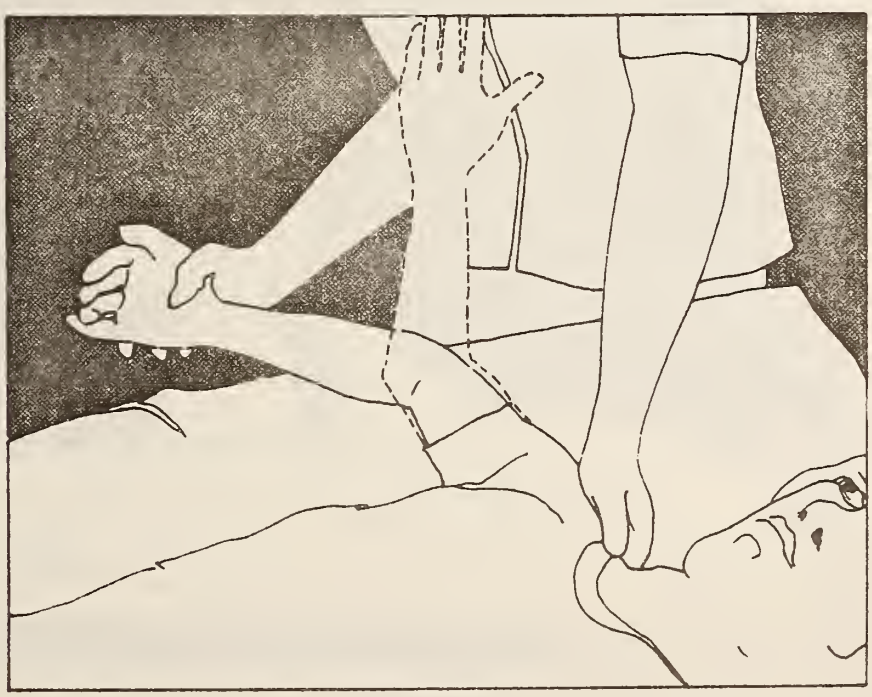

Figure 14
Internal Rotation of Shoulder

Step 10. Finish the movements by returning the arm to the patient's side, resting the hand on the surface of the bed towards the foot of the bed (movements completed).

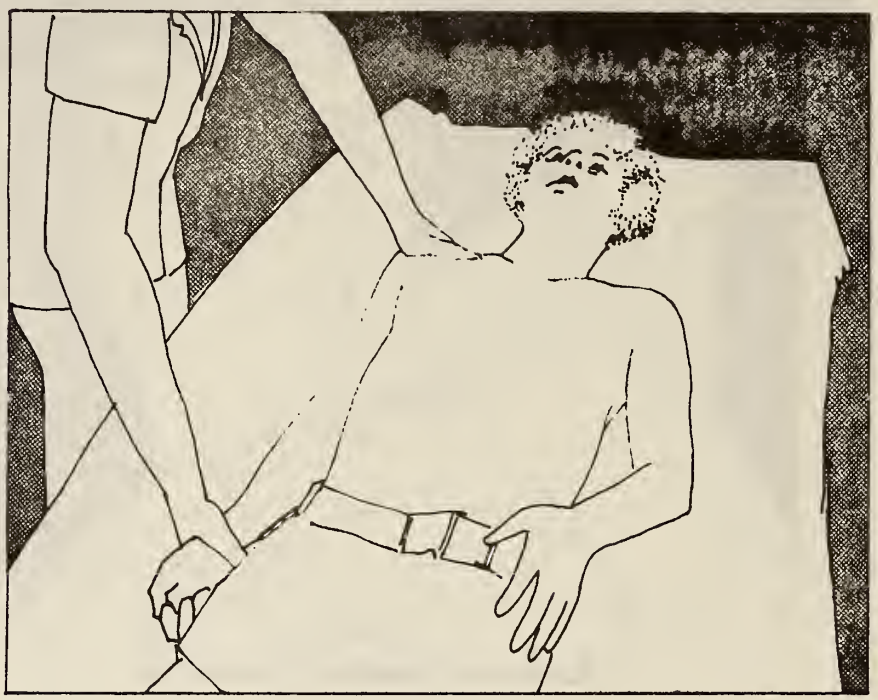

Figure 15
Movements Completed

B. Lower Extremities

Step 1. Grasp the foot and leg, dorsiflex the ankle (ankle flexion).

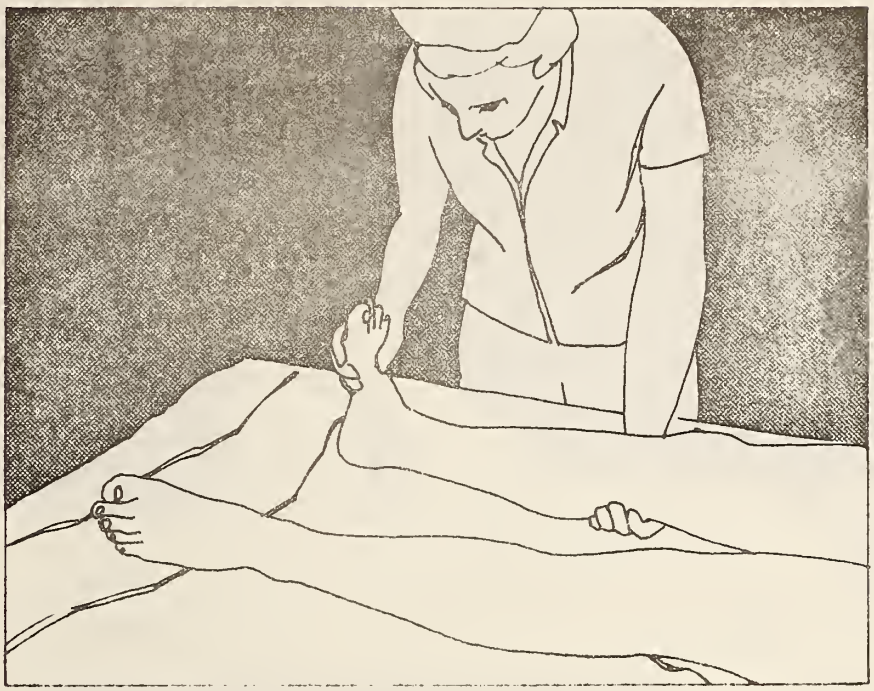

Figure 16
Ankle Flexion

Step 2. Simultaneously flex the knee (knee flexion).

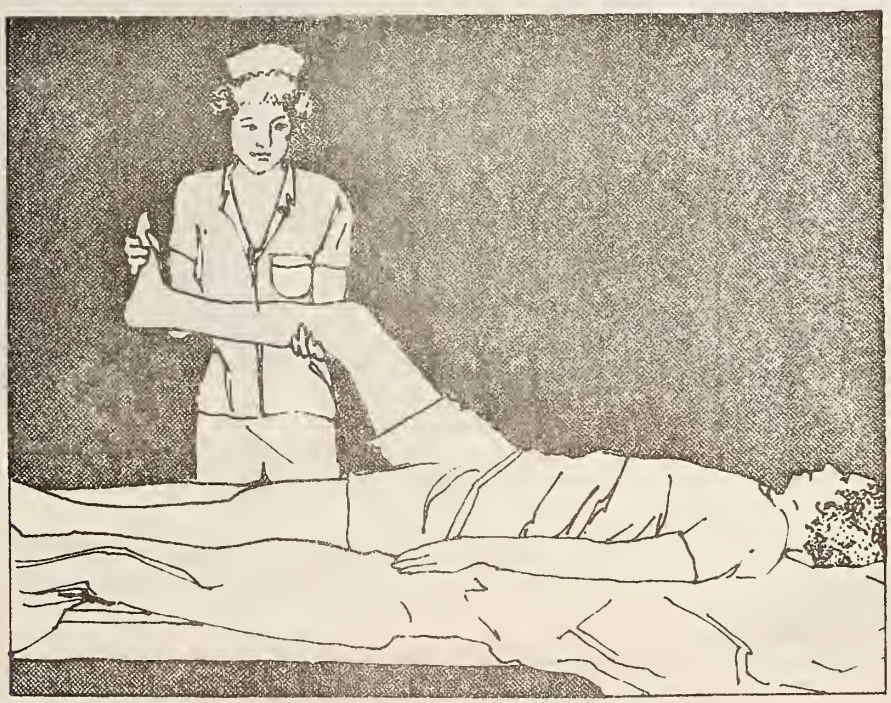

Figure 17
Knee Flexion

Step 3. Flex the hip (hip flexion).

Figure 18
Hip Flexion

Step 4. From the Step 3 position, extend the knee and hip simultaneously returning the limb to the starting position on the bed (knee extension, hip extension).

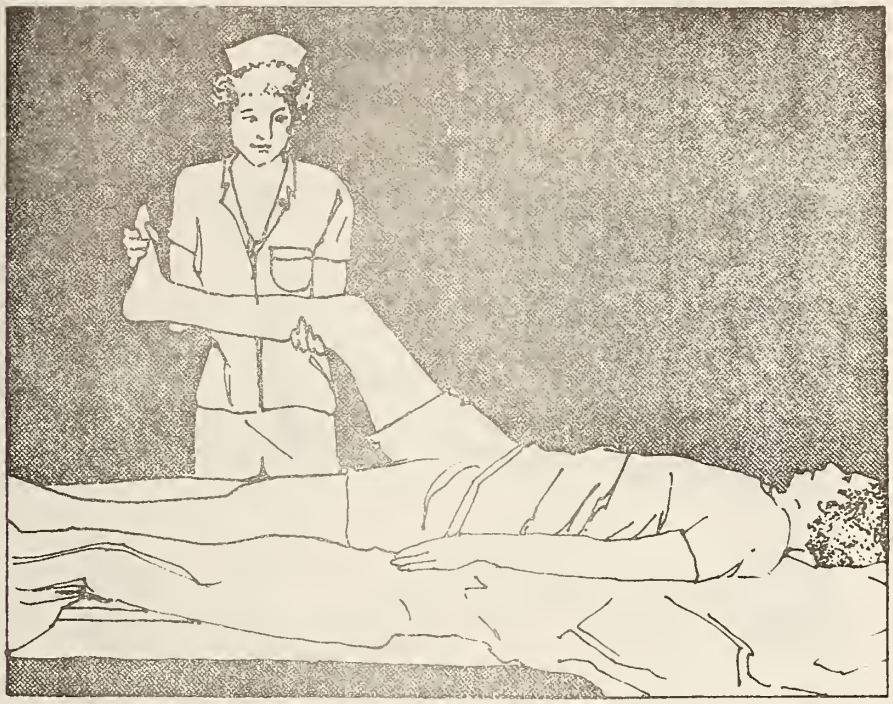

Figure 19
Hip and Knee Extension (Mid-point)

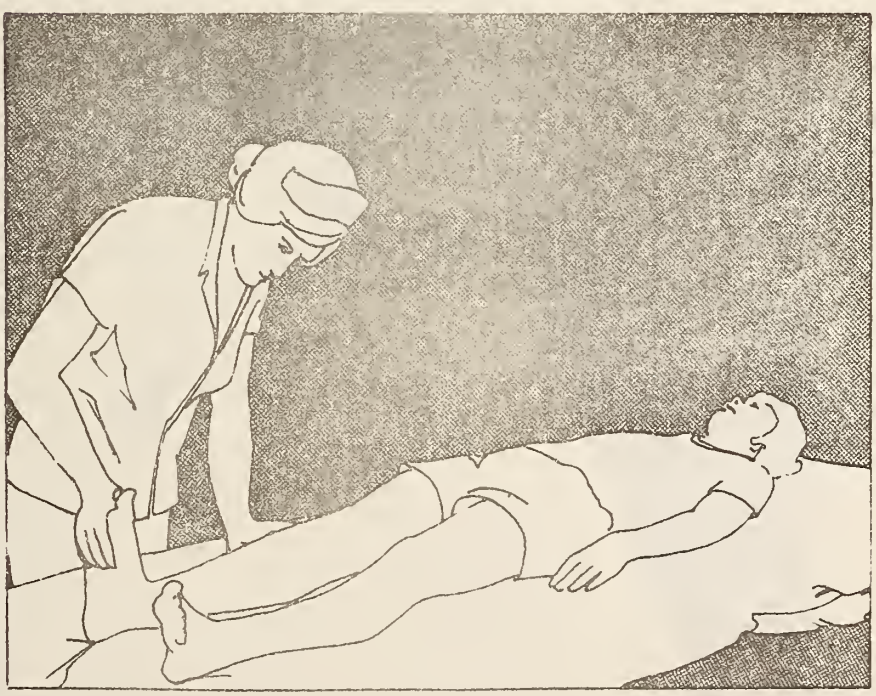

Figure 20
Hip and Knee Extension (Completed)

Step 5. Extend the ankle (ankle extension).

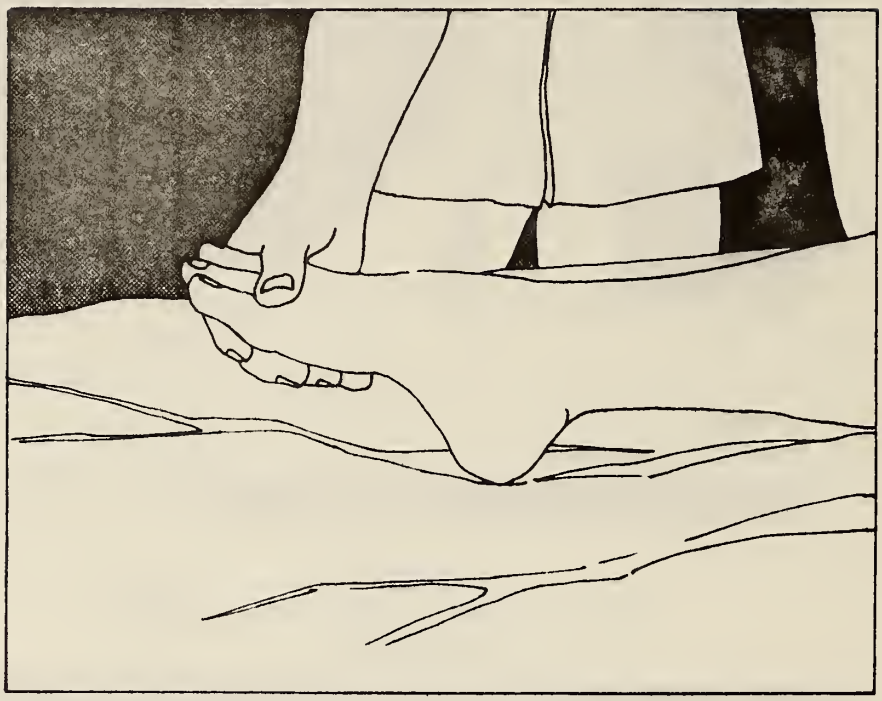

Figure 21
Ankle Extension

Step 6. With all joints in the lower extremity, fully extended, and with the limb in good alignment, move the leg parallel to the surface of the bed and away from the midline of the body (hip abduction).

Figure 22
Hip Abduction

Step 7. Return the limb to the midline (hip adduction).

Figure 23
Hip Adduction

Step 8. Roll the leg inward (hip internal rotation).

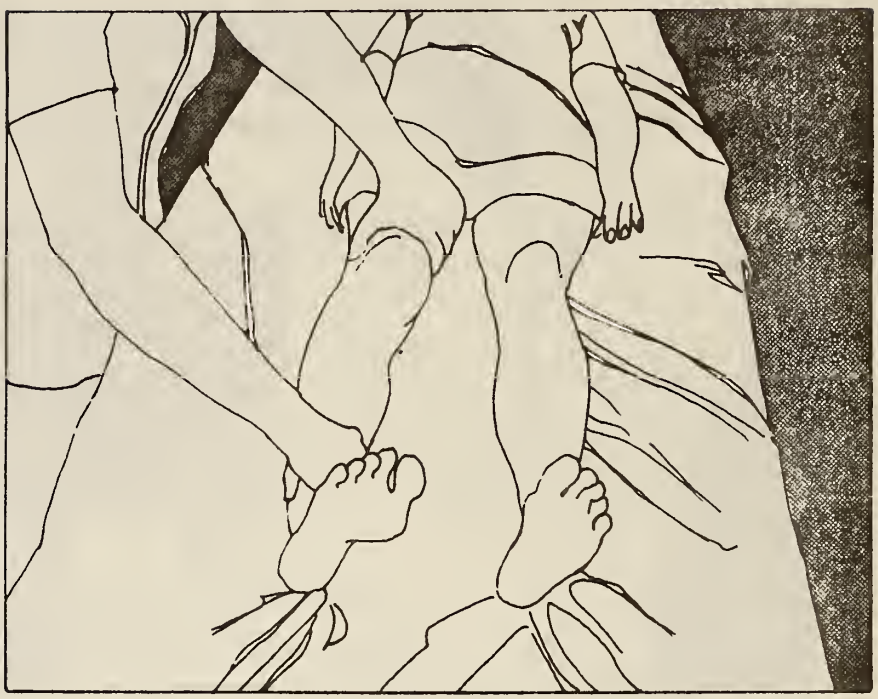

Figure 24
Hip Internal Rotation

Step 9. Roll the leg outward (hip external rotation).

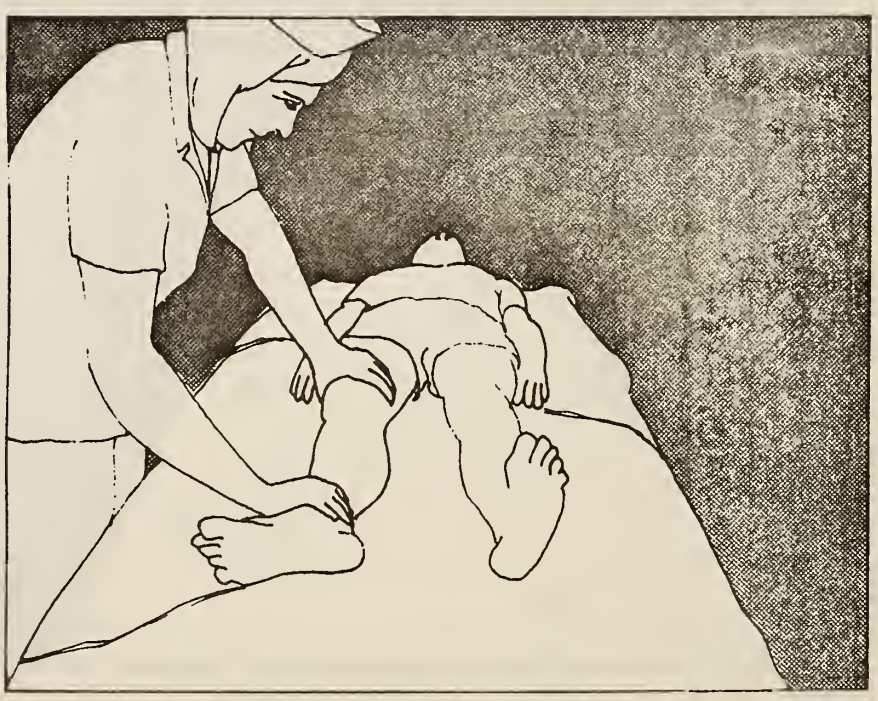

Figure 25
Hip External Rotation

3. **Head and Trunk**
With patient sitting erect and unsupported on side of bed, test range of motion of head and trunk. If he cannot sit unsupported on side of bed for any reason, note the reason and indicate test cannot be completed. If appropriate, complete test at later date.

Side-to-Side

Step 1. Instruct the patient to turn his/her head in one direction, either right or left.

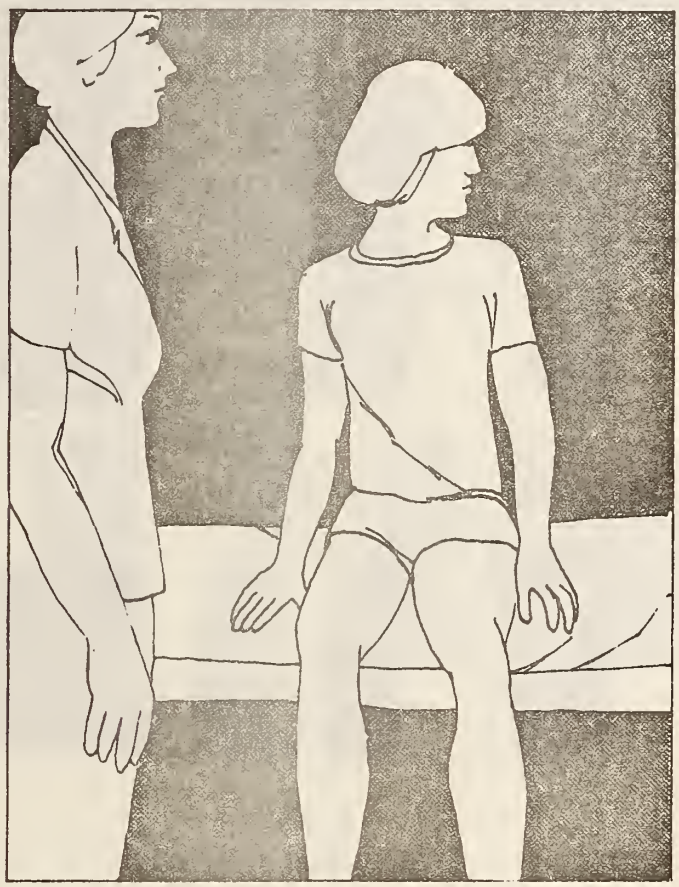

Figure 26
Side-to-Side Head

Step 2. Then instruct patient to turn his/her trunk as far as possible in the same direction, as if looking at something behind him.

Figure 27
Side-to-Side Trunk

Step 3. Then reverse the motion as far as possible in the opposite direction, head and trunk, side-to-side.

Figure 28
Side-to-Side Head and Trunk

Step 4. Instruct the patient to tilt his head forward until his chin rests on his/her chest (head flexion) then in this position, to proceed to Step 5.

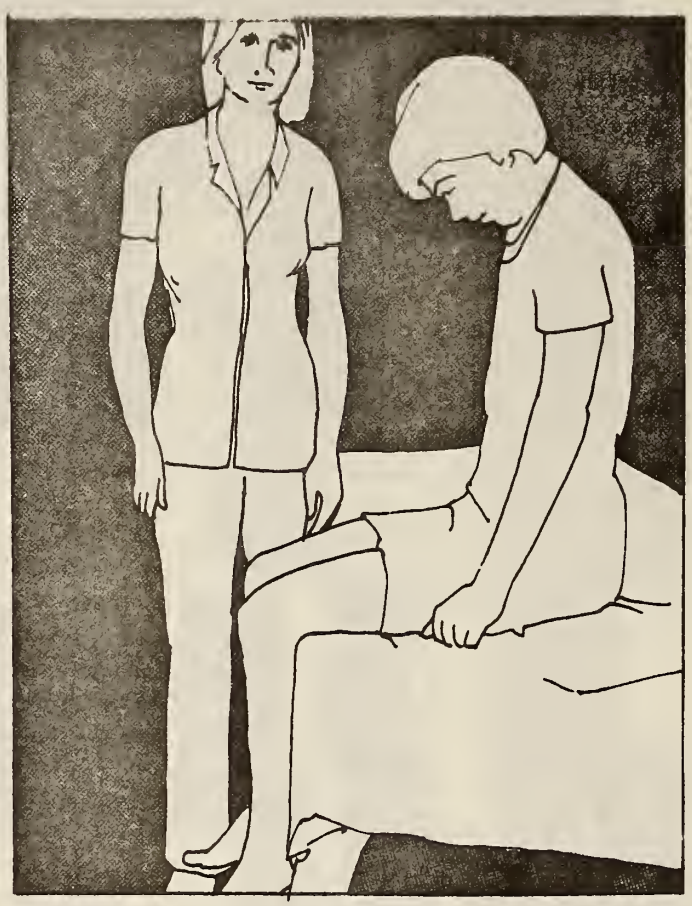

Figure 29
Flexion/Extension. Head Flexion

Step 5. Bend his trunk forward until his chest rests on his thighs (trunk flexion).

Figure 30
Flexion/Extension, Trunk Flexion

Step 6. Instruct the patient to straighten up by raising his trunk (trunk extension) and then to proceed to Step 7.

Figure 31
Flexion/Extension, Head and Trunk Extension

Step 7. **Raise** his chin upward toward the ceiling as high as possible (head extension).

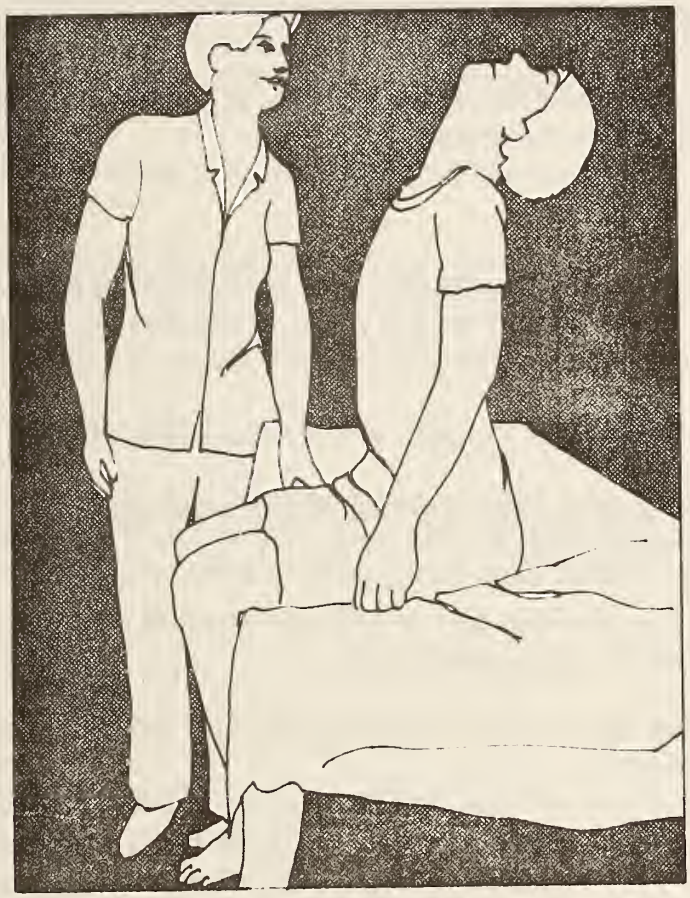

Figure 32
Flexion/Extension, Head Extension

SUMMARY OF INSTRUCTIONS FOR RANGE OF MOTION EXERCISES

Begin the examination with the upper right extremity and continue with the lower right extremity. Then begin with the upper left extremity and finish with the lower left extremity.

A. Upper Extremities

Step 1. Grasp the patient's hand and flex the wrist, fingers, and thumb (hand, finger, thumb flexion).

Step 2. Flex the elbow

Step 3. Flex the shoulder until the inner surface of the forearm rests on the brow of the head. Move the upper arm as close as possible to the surface of the bed (shoulder flexion).

Step 4. Extend the wrist, fingers, and thumb (hand, finger, thumb extension).

Step 5. Fully extend the elbow so that the forearm rests on the bed (shoulder and elbow extension).

Step 6. Move the arm parallel to the bed surface out and away from patient's midline (shoulder abduction).

Step 7. Reverse the motion, returning the arm to the patient's side (shoulder adduction).

Step 8. Straighten shoulder away from body (90°) keeping arm parallel to the bed, flex the elbow upright 90°. Rotate the shoulder by taking the patient's hand toward the bed surface at the head of the bed (external rotation of shoulder).

Step 9. Now, rotate the shoulder by taking the patient's hand toward the bed surface at the foot of the bed (internal rotation of shoulder).

Step 10. Finish the movements by returning the arm to the patient's side, resting the hand on the surface of the bed towards the foot of the bed (movements completed).

B. Lower Extremities

Step 1. Grasp the foot and leg, dorsiflex the ankle (ankle flexion).

Step 2. Simultaneously flex the knee (knee flexion).

Step 3. Flex the hip (hip flexion).

Step 4. From the Step 3 position, extend the knee and hip simultaneously returning the limb to the starting position on the bed (knee extension, hip extension).

Step 5. Extend the ankle (ankle extension).

Step 6. With all joints in the lower extremity, fully extended, and with the limb in good alignment, move the leg parallel to the surface of the bed and away from the midline of the body (hip abduction).

Step 7. Return the limb to the midline (hip adduction).

Step 8. Roll the leg inward (hip internal rotation).

Step 9. Roll the leg outward (hip external rotation).

3. Head and Trunk

With patient sitting erect and unsupported on side of bed, test range of motion of head and trunk. If he cannot sit unsupported on side of bed for any reason, note the reason and indicate test cannot be completed. If appropriate, complete test at later date.

Side-to-Side

Step 1. Instruct the patient to turn his/her head in one direction, either right or left.

Step 2. Then instruct patient to turn his/her trunk as far as possible in the same direction, as if looking at something behind him.

Step 3. Then reverse the motion as far as possible in the opposite direction, head and trunk, side-to-side.

Flexion and Extension (head and trunk)

Step 4. Instruct the patient to tilt his head forward until his chin rests on his/her chest (head flexion) then in this position, to proceed to Step 5.

Step 5. Bend his trunk until his chest rests on his thighs (trunk flexion).

Step 6. Instruct the patient to straighten up by raising his trunk (trunk extension) and then to proceed to Step 7.

Step 7. Raise his chin upward toward the ceiling as high as possible (head extension).

B. Strength, Balance and Coordination

General Information

These tests require that the patient move from his bed to a standing position beside his bed. Therefore, the bed surface should be low enough to enable his feet to rest flat on the floor when he is sitting on the edge of his bed. A chair with arms should be placed next to the patient's bed. He should be comfortable and free of restrictive clothing. Instruct the patient to indicate any pain during any motion.

Instructions

Tests in this section require active participation by the patient. The nurse-appraiser must explain, and the patient clearly understand, the directions for performing each test.

Place a checkmark in the appropriate space(s) beside each question. If necessary, specify other observations in the margin to the right of each question.

Tests 1 and 2 are initiated and completed with the patient in the supine position. Test 1 requires that the patient hold his heel 10 inches above the bed's surface for 5 seconds. Test 2 requires that the patient roll from supine to prone in each direction.

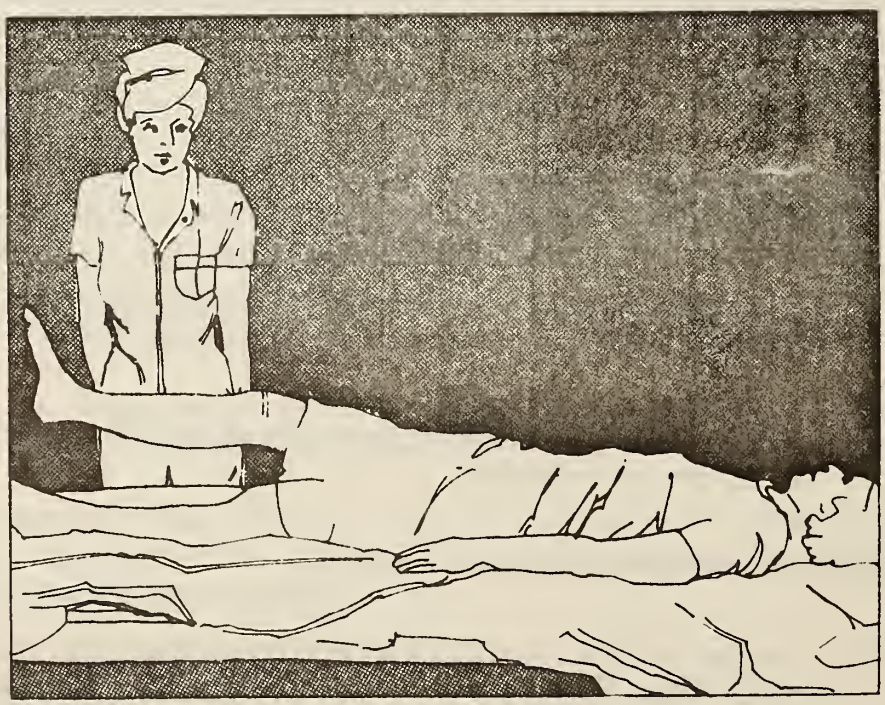

Figure 33
10" Leg Raise

Test 3 is carried out by asking the patient to sit up in bed and swing his legs over the side of the bed.

Test 4 is also conducted with patient sitting up in bed. This test involves checking the patient's handgrip. The nurse examiner should extend only the first two fingers of one hand (not the whole hand) to be grasped by the patient.

Test 5 is initiated with the patient sitting up in bed unassisted and with legs over the side of the bed, and completed with the patient standing as erect as possible and unsupported. He may or may not need to use the chair arms or bed surface for support in order to reach the standing position. The patient is then instructed to remain standing.

Figure 34
Using the chair for support to stand up

Test 6 is initiated and completed with the patient standing erect and unsupported. The patient should be instructed to raise both arms simultaneously to a position above his head, holding for 5 seconds. The patient should then be instructed to lower his arms and return to a sitting position on the side of the bed.

Figure 35
Standing Erect, Elbows Extended

Tests 7 and 8 require that the examiner make a judgment as to whether the patient appears to have had normal coordination and balance while moving body parts throughout the above tests, 1 through 6.

C. Activities of Daily Living

Instructions

Complete *all* functioning status items at each assessment.

Place a checkmark in each column in the chart that applies and a dash in each column that does not apply.

The column entitled # *Persons Helping* requires a number.

If any activity requires both mechanical aid *and* human help, check both columns and enter a number in the column entitled *Person Helping.*

Indicate the way each activity is *actually* performed rather than the patient's potential ability. Indicate *usual* performance for each item, *usual* means more often than not, within the two weeks prior to the date of the appraisal.

Appraise performance in the usual setting rather than in a therapeutic session, e.g., in the patient's room, rather than in the physical therapy area.

If the policy of the facility does not permit the patient to carry out any of the activities without supervision, e.g., go outside, bathe, climb stairs, etc., indicate this on the form with an asterisk and note: "nursing home policy."

General Definitions

No Problem	Patient performs the activity independently
Mechanical Aid	The activity is performed with the use of particular equipment or devices, such as walkers, tripod or quad canes, sliding board, trapeze, leg braces, splints, prostheses, special shoes, specially adapted eating utensils, etc. The use of architectural features such as handrails, ramps, furniture, etc., to perform an activity is also considered the use of mechanical aid
Human Help	The presence of one or more persons is a necessary part of the performance of the activity. This may take different forms, e.g., another person is necessary to partially perform the activity for the patient or another person must guard, guide, protect, observe, or supervise, the patient at the time of the activity
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	If the activity is performed with the help from another person(s) *and* particular equipment or devices, check the categories Mechanical Aid and Human Help and enter the number of persons needed to help
Does Not Perform	The patient does not participate in the performance of any part of the activity, and is bathed, is dressed, is transferred, etc. entirely by someone else

Specific Definitions

1. Mobility	The patient's ability to move about within his environment
a. *Goes outside*	Patient goes outside of the facility, e.g., to gardens, porch, sidewalk, etc., on a regular basis. It includes transfer by taxi to doctor's office, clinics, or hospitals
No problem	Goes outside the facility and returns without assistance by another person, equipment or devices
Mechanical Aid	Goes outside and returns by using aids for walking—such as leg braces, splints, special

	shoes, canes, crutches, walkers, etc., and equipment such as wheelchair or chairlift. Handrails, ramps and other architectural fixtures are considered equipment used by the person if he goes outside only with their use
Human Help	One or more persons help the patient when he goes outside the facility by providing physical support; propelling wheelchair on ramp; carrying the patient. Guarding, guiding, protecting, or supervising the patient is considered help if he gets outside only with this help
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechnical Aid	If both required, enter checks in Human Help and Mechanical Aid; enter number in # Persons Helping
Does Not Perform	Does not go outside the facility but moves about or is moved only into other rooms or sections within the facility
b. *Walking*	The process of moving about on foot, ambulation. The term includes such movements on artificial limbs
No problem	Receives no assistance or supervision from another person, nor from use of equipment or devices
Mechanical aid	Walks with the use of such items as leg braces, splints, canes, crutches, special shoes, back braces, and walkers. Architectural fixtures such as handrails or furniture such as nonwheel chairs, are considered equipment or devices, if the individual walks only with their use
Human help	A relationship of helper(s) and patient. Examples are physical support, guarding, guiding, protecting, and supervising; these are considered help if the patient walks only with this help. Observation is regarded as help if walking is permitted only with an observer present
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	Walks with a combination of human help and equipment or devices. Enter checks in Human Help and Mechanical Aid; enter number in # Persons Helping column

Does Not Perform	Does not walk. Patient may be helped to take a few steps from bed to chair, but this does not constitute walking
c. *Climbing Stairs*	The process of going up and down a flight of stairs from one floor to another within the facility but not including minimal variations in floor levels, as between rooms
No problem	Receives no assistance or supervison from another person, nor from use of equipment or devices, in going both up and down a flight of stairs
Mechanical Aid	Climbs stairs with the help of equipment or devices. Examples are leg braces, splints, special shoes, canes, crutches, walkers, and special handrails. Handrails are considered equipment for stair climbing only if the individual uses them to ascend or descend a flight of stairs
Human Help	Receives physical support from another person or persons going up, or down, stairs or both. Guarding, guiding, protecting, and supervising are considered help if the person usually goes up and down stairs only with this help
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	Climb stairs with the help of another person or persons and equipment or devices. Enter checks in Mechanical Aid and Human Help; enter number in # Persons Helping
Does Not Perform	Cannot climb stairs, includes persons who manage steps or curbs but not a flight of stairs, or who uses vertical elevators in the building rather than stairs or who do not climb stairs because of disabilities
d. *Transferring*	The process of moving horizontally between the bed and chair, wheelchair, or stretcher
No problem	Patient receives no assistance or supervision from another person, nor from use of equipment or devices when transferring
Mechanical Aid	Transfers with the help of equipment or devices such as sliding board, overhead pulley, trapeze, special bed, special bed railings, etc.
Human Help	Transfers with the help of another person or persons. Includes person(s) guarding, guiding, protecting, or supervising the patient in

	the process of transferring. Other examples include getting out of bed to floor or chair; getting from chair or standing position into bed, onto toilet, into shower, raising from chair or toilet, etc.
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	Transfers with the help of another person or persons and equipment or devices; enter checks in Mechanical Aid and Human Help; enter number in # Persons Helping column
Does Not Perform	Patient is lifted out of bed, chair, etc. by another person or persons, and does not participate in the process. This category may also include the use of equipment or device, e.g., three persons and a Hoyer lift. Includes bedfast patients
e. *Wheeling*	The process of moving about by means of any device equipped with wheels (e.g., wheelchair, cart)
No problem	Patient can use a wheelchair without assistance or supervision of another person or without use of equipment or devices
Mechanical Aid	Patient wheels himself with the help of an adaptive device. Devices used in wheeling are adaptations of a standard wheelchair. Examples are: electric power driven amputee wheelchairs
Human Help	Patient wheels himself with help from another person to get through doorways, lock and unlock the brakes, learn to use the wheelchair (safety factors), and to get up and down ramps
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	If patient wheels himself with help from another person and equipment or device; enter checkmark in Human Help and Mechanical Aid; enter number in # Persons Helping column
Does Not Perform	Patient is transported in a wheelchair but does not propel or guide it. He may wheel a few feet within an activity area, but this alone does not constitute wheeling

2. Personal Care

a. *Bathes/Showers* — The process of washing the body or body parts whether or not the bath is taken or given in bed, shower or tub

No problem — Patient receives no assistance or supervision in bathing from another person nor from the use of special equipment or devices

Mechanical Aid — Bathes self with use of equipment such as grabrails, handle bars at the sink, shower chair, etc., or devices such as long handled brush, mitten face cloth, etc.

Human Help — Is helped by another person who brings water and equipment to him then bathes self completely or receives additional assistance, e.g., with back, legs, feet, etc.

Persons Helping — Designates the *number* of persons whose presence is necessary for the performance of the activity

Human Help and Mechanical Aid — Receives help from another person *and* uses special equipment or devices; enter check mark in Mechanical Aid and Human Help; enter number in # Persons Helping column

Does Not Perform — Patient is completely bathed by another person, whether the bath is given in bed, shower, or tub. He does not participate in washing any part of his body

b. *Toileting* — The process of getting to and from the toilet room for elimination of feces and urine, transferring on and off the toilet, cleansing self after elimination and adjusting clothes. (A commode in any location may be considered the "toilet room" only if, in addition to meeting the criteria for "toileting", the patient empties, cleanses and replaces the waste receptacle without assistance of another person).

No problem — Patient toilets self, with no assistance or supervision from another person, nor from any equipment or devices

Mechanical Aid — Uses the toilet room with the help of equipment or devices, which may include raised toilet or raised toilet seat, handrails, grab bars, wheelchair, walker, cane, transfer board, etc.

Human Help — Patient requires assistance from another person(s) in getting to and from the toilet room, transferring on and off the toilet seat, cleansing after elimination, and adjusting clothes

# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	Uses the toilet room with the help of another person or persons and equipment or devices; enter check mark in Mechanical Aid and Human Help; enter number in # Persons Helping column
Does Not Perform	Uses other means than toilet for elimination such as urinal, bedpan, or commode (see Toileting above)
c. *Dressing*	The process of putting on, fastening, and taking off all items of clothing, braces, and artificial limbs that are worn daily by the individual. It includes obtaining items from their storage area in the immediate environment and replacing them. (Dressing refers to the clothing usually worn daily by the individual. People who wear pajamas or gown with robe and slippers as their attire are considered dressed, but a note should be made under, Remarks)
No problem	Patient dresses without assistance or supervision from another person and without the help of equipment or devices
Mechanical Aid	Patient dresses with the use of equipment, such as a walker with attached clothing basket to get to and carry clothes; adaptive devices such as a long handled shoe horn, or a zipper pull; or adapted clothing, such as wide pant legs, front hooking bra, etc.
Human Help	Another person(s) helps the the patient dress. Includes merely obtaining patient's clothing, but would also include additional steps on putting on clothes, fastening hooks, buttons, zippers, etc.
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	Receives help from another person *and* uses special equipment or devices; enter check mark under Mechanical Aid and Human Help; enter number in # Persons Helping column
Does Not Perform	Patient is dressed completely by another person and does not participate in this activity, or is confined to bed and is considered not dressed

d. *Grooming*	The daily process of brushing or combing hair, brushing teeth, taking care of dentures, shaving
No Problem	Patient grooms self without assistance or supervision from another person and without the use of special equipment or devices
Mechanical Aid	Patient grooms himself with the use of equipment such as long handled comb, electric toothbrush, special shaving equipment
Human Help	Patient grooms self with assistance or supervision of another person(s) either in obtaining grooming tools or materials or actually performing the task in whole or in part
# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	Receives help from another person and uses special equipment or devices, enter check marks under Mechanical Aid and Human Help; enter number in # Persons Helping column
Does Not Perform	Patient is groomed completely by another person and does not participate in any part of this activity
e. *Eating*	The process of getting food by any means from the receptacle (plate, cup, glass, bottle, etc.) into the body by mouth after the food is placed in front of the patient
No Problem	Patient feeds self without assistance from another person nor from the use of special devices. He cuts food, butters bread, pours beverages, handles utensils, and conveys food to mouth
Mechanical Aid	Patient feeds self with the help of such adaptive devices as utensils with large handles; rocker spoons; forked knives. Other devices include plate guard; hand splints; suction dishes, nonskid plates, etc.
Human Help	Patient feeds self with the help of another person in cutting meat, buttering bread, opening cartons, fixing straws, pouring milk on cereal, pouring cream in coffee, or putting food on fork or spoon. Includes assistance with some foods, e.g., soup. Special diets are not considered help

# Persons Helping	Designates the *number* of persons whose presence is necessary for the performance of the activity
Human Help and Mechanical Aid	Patient feeds self with the help of another person and an adaptive device; enter check marks under Mechanical Aid and Human Help; enter number under # Persons Helping column
Does Not Perform	Patient is fed by another person and does not bring any food to mouth; includes being fed a prescribed liquid via a naso-oral gavage tube or gastrogavage tube; a prescribed sterile solution by clysis or intravenously. Record "Tube Fed" or "Fed Parenterally" under Remarks

DENTAL/ORAL STATUS

GENERAL INFORMATION

Dental/Oral Status block (QI-C), when completed, provides indications of the status of the natural teeth, if any, whether the individual has dentures (full or partial), and the status of the oral soft tissue.

The Dental/Oral Status examination may be completed by the Appraiser, who needs to use only a dental mirror and flashlight to observe the patient's teeth and mouth.

Instructions

Natural Teeth

For each finding, as described below, put a check mark in the appropriate boxes. If there is no finding, put a dash in the appropriate box to indicate the test was performed, unless otherwise directed.

If the patient has no natural teeth, check space titled: None. If none, go on to block entitled: Dentures: Complete or Partial.

If the patient has natural teeth, indicate the approximate number present (upper and lower jaw, combined). Indicate if any tooth is decayed or fractured.

Examine for looseness and pain by pushing gently against each natural tooth with the dental mirror. Indicate if any tooth appears to be painful or loose.

Inspect for the presence of debris, film, plaque, calculus (tartar), or stain, using the flashlight and dental mirror. Use space titled: Unclean:

If there is no decay, fracture, pain, looseness or uncleanliness, check the space titled: Satisfactory.

Dentures, Complete or Partial: For each finding, as described below, put a check mark in the appropriate boxes. If there is no finding, put a dash in the appropriate box to indicate the test was performed, unless otherwise directed.

If the patient has no complete or partial dentures, check space titled, None. If none, go on to the block titled: Oral Soft Tissue.

If the patient has dentures, indicate whether upper or lower plate, or both. Indicate if the patient uses the upper or lower plate for chewing.

Examine for fit and comfort by pushing gently against each plate with the dental mirror while observing with the flashlight. Indicate if either plate is uncomfortable or loose.

With the dentures out of the patient's mouth, examine for broken or missing parts or teeth, and for cleanliness. Indicate if any condition is observed.

If the dentures are not broken, have no missing teeth, are not uncomfortable, loose or unclean, check the space titled: Satisfactory.

Oral Soft Tissue: For each finding, put a check mark in the appropriate boxes. If there is no finding, put a dash in the appropriate box to indicate the test was performed, unless otherwise directed.

Remove the patient's dentures from the mouth. Use the flashlight and dental mirror throughout the examination.

Indicate if there is inflammation of any surfaces of the upper or lower gums.

Question the patient and look for evidence of dry mouth. Indicate if there is any, or if the patient complains of it presently.

Inspect all surfaces of the mouth, including tongue, lips, palate, cheeks, gums, and under the tongue for the presence of ulcers, sores, lumps, abscesses, or other lesions. Indicate if any condition is noted.

Other Dental/Oral Problems: If any problem or condition not covered above is observed, or complaint made, describe in space provided.

NUTRITIONAL STATUS

General Information

Questions 1-9 examine the dimensions of the patient's nutritional status, and identify if he has a problem accepting, eating or digesting food. The individual's needs should be identified according to accepted nutritional standards of quality of care.

Instructions:

Q. 1, 2, and 3 should be answered, initially, by placing a check mark in a *Yes* or a *No* space.

If the answer to Q. 1 is *No,* proceed to Q. 2. If *Yes,* place a check mark opposite each diet that applies.

If the answer to Q. 2 is *No,* proceed to Q. 3. If *Yes,* place a check mark opposite each intake problem that applies.

If the answer to Q. 3 is *No,* proceed to Q. 4. If *Yes,* place a check mark opposite each output problem that applies.

Q. 4, 5, 6. If the answer is yes, complete the subsections as indicated.

For Q. 7 identify in writing the usual dining location.

Definitions

Nutrition	The taking in of food and fluid and the assimilation of the nutrients through bodily chemical changes (metabolism), in which body tissue is built up and energy released
1. Diets	
Regular Diet	A variety of foods that provides sufficient protein, vitamins, minerals and calories to meet recommended dietary allowances

Special Diet	Any prescribed diet other than a regular diet
a. Mechanical Soft Diet	Mechanically altered regular diet for patients who have difficulty in chewing and/or swallowing
b. Bland-Low Residue Diet	Mechanically and chemically non-stimulating foods, usually given in six small meals
c. Diabetic Diet	A measured diet adapted to meet the individual diabetic patient's requirements. Physicians' orders usually specify the grams of protein and carbohydrate and the total calories desired or one of a series of meal plans described in the facility's diet manual
d. Calorie Restricted Diet	A nutritionally adequate diet which controls calorie intake to help an individual achieve weight reduction or maintain desirable weight
e. Sodium Restricted Diet	Nutritionally adequate diets designed to limit the amount of sodium in the diet. Physicians' orders indicate milligrams of sodium desired, or one of a series of sodium restricted diets described in the facility's diet manual
f. Fat Modified Diet	A nutritionally adequate diet which regulates both the amount and type of fat
g. Other	Any therapeutic diet other than those listed above, e.g., low protein diet
2. Intake Problems	The patient manifests a problem with eating or drinking, such as having difficulty in swallowing, refusing to eat, or drink, refusing to follow diet, etc.
a. Solid Food	Problem may be manifested by weight gain or loss
b. Fluid	Problem may be manifested by dehydration
3. Output Problems	Patient manifests a problem with excreting body waste (e.g., urine, feces)
a. Constipation	Difficult or infrequent passage of feces with passage of unduly hard and dry feces
b. Diarrhea	Morbid frequency of bowel evacuations with stool having a more or less fluid consistency
c. Fluid Retention	Collection or retention of fluids in the body such as edema and ascites
d. Other	Any other output problem not listed above; e.g., patient has a tendency to become dehydrated
4. Food Likes and Dislikes	The patient's food and beverage preferences
a. Recorded	Preferences are recorded in patient's dietary record

b. Carried out	Within medical limitations, preferences and dislikes are honored in the patient's diet.
5. Cultural/Religious Food Constraints	Food or diet constraints arising from patient's cultural or religious background
6. Supplementary Nourishments	Food or fluid given to a patient other than that routinely given to all patients, e.g., high protein commercial liquid preparation
7. Usual Dining Location	The place where the patient eats his main meal (generally the noon meal). If in room, indicate whether patient dines while in chair or bed
8. Weight (this appraisal)	Patient's weight on day of appraisal or most recent measurement
9. Weight Change	Significant change of weight within the last three months (e.g., more than five lbs.)

PSYCHOSOCIAL FACTORS

Psychosocial Factors describe the patient's adjustment to care, his social interaction, his adjustment to the facility, and his usual behavioral patterns.

Instructions

These sections should be completed by placing check marks in the appropriate space or column.

The sections should be completed by the nurse appraiser eliciting information from the person or persons most able to describe the patient's pattern of psychosocial behavior.

Note the A. 1-6, *Patient's Adjustment to Care Plan,* may not be applicable during initial appraisal, but should be completed during each subsequent appraisal.

B. 1-17, requires one check mark in one of the three categories for each item; if four or more items are checked *Never,* then consideration should be given to having patient examined by a psychiatrically oriented professional such as a psychiatric or other qualified social worker, psychiatric nurse, clinical psychologist or psychiatrist.

It is advisable that an amount of time suitable for the patient to adjust to the facility be permitted following admission. Complete the section just prior to the first care planning meeting.

For each *Behavioral Problem* item in C. 1-15, identify first whether or not the patient exhibits such behavior. If not, place a check mark in column (A) opposite that item. If he does, then indicate whether his behavior is affecting his functional capacity or necessitates additional care and/or supervision and check the appropriate column opposite that item.

If behavior affects functional capacity of the individual or necessitates additional care and/or supervision, then consideration should be given to having the patient examined by a qualified professional as indicated above in section B.

Definitions

Psychosocial Factors	Items that appraise the patient's psychological and social status, including his affective, cognitive and behavioral dimensions, and his participation in social activities

A. Patient's Adjustment to Care Plan

Care Plan	Detailed, step-by-step plan of health care designed to meet specified objectives resulting from appraised identification of problems
Family/Surrogate	Family: Self Explanatory Surrogate: A person, not a family member, who holds a positive meaningful relationship with patient; significant other
Involvement	Patient and/or family/surrogate has involved self in articulating goals for patient's health care
Cooperation	Patients and/or family/surrogate has demonstrated willingness to contribute to and accomplish goals of care plan
Educational Experience	A scheduled, formal session in which a professional with patient and/or family/surrogate explains care plans and answers questions

B. Patient's Social interaction and Adjustment to the Facility

Pattern of Behavior	Usual manner of conducting one's self within one's environment. Consideration should always be given to the patient's previous life style and behavior in evaluating any of these items
Usually	Patient has been observed *repeatedly* to exhibit a particular behavior
Occasionally	Patient has been observed *at times* to exhibit the particular behavior
Never	Patient has *at no time* been observed to exhibit the particular behavior
1. Is oriented to the time and space of living environment	Self explanatory
2. Cooperates with rules and regulations	The patient's ability to conform to the demands of institutional living, as expressed in rules and regulations. It is important to note that these requirements always reduce the independence a patient had before entering the facility. Difficulty in conforming may indicate that the loss of independence is viewed as very significant by a particular patient. It could also indicate "overregulation" by the facility, especially when large numbers of patients fail to cooperate

3. Asserts self and makes needs known	Measures a patient's ability to maintain and assert an individualized sense of self. Expression of one's uniqueness, especially in an institutional environment, is a sign of social and emotional health. If uniqueness is not expressed, it could be a symptom of depression. If seldom expressed by most patients, a facility-level problem may exist because such expression is not permitted or encouraged
4. Participates in self-directed activities	Carries out daily activities such as reading, writing letters, sewing, woodworking or other available crafts.
5. Personalizes living space	Adds such items as lamps, flowers, plants, etc. (as permitted) to room
6. Personalizes apparel	Wears own clothes, or adds items such as jewelry to clothing
7. Participates in structured activity program	Patient's use of the facility. An individual item may reflect the life style and personal taste of an individual, e.g., he participates in structured activities only occasionally, may mean he simply does not like such activities
8. Eats in dining room (if physically capable)	Self explanatory
9. Spends free time outside his/her own room	Self explanatory
10. Has visitors from outside the facility	The patient's links with people or events in the world outside the facility. A pattern of isolation from the outside world indicates intensified dependency on the institution for interaction. Strong link(s) with the outside world could compensate for minimal involvement in the facility
11. Visits others outside the facility	Leaves the facility to visit. May be for a few hours or even for days at a time.
12. Has other outside contacts, i.e., letters, calls, etc.	Self explanatory
13. Talks about events that go on outside the facility	Self explanatory
14. Engages in conversation with staff	The quantity and appropriateness of a patient's interactions with others in the facility. Some people are normally more socially active than others, but patterns of isolation or inappropriateness should be taken seriously

15. Engages in conversation with fellow patients	See above
16. Relates in an appropriate adult manner to fellow patients	Does not exhibit bizarre or other inappropriate language, mannerisms, etc.
17. Relates in an appropriate adult manner to staff	See above
C. Behavioral Problems	
Interferes with Functional Capacity	Behavioral problems cause patient difficulty in performing activities of daily living
Special Care	Behavioral problems require that patient be given assistance in performing activities of daily living
Additional Supervision	Custodial and/or supervisory help is required
1. Apprehensive	Uneasy, worried or fearful about something that may happen
2. Withdrawn	Failure to initiate contact with others and unresponsive when approached by staff and other patients
3. Hyperactive	A state of almost constant and exaggerated physical or verbal activity
4. Abusive to self	Intentionally injures self (physical abuse) or berates self (verbal abuse)
5. Disruptive	Throwing the environment into disorder by physical or verbal actions; e.g., moving around and talking loudly during movie or bingo game, crying out loudly during the night, etc.
6. Hostile	Expressing, in actions and/or words, exaggerated feelings of anger, dislike or opposition to others, e.g., makes statements which are hurtful
7. Abusive to others (physical, mental, sexual)	Berates others or uses foul language (verbal abuse) or strikes or uses force or violence to do harm to others
8. Wanders	Roams or strays from proper limits or moves about aimlessly or without a fixed goal
9. Forgetful	Absent-minded, unable to recall recent events or unable to remember scheduled future events

10. Confused	Disturbed orientation with respect to time, place or person, e.g., patients may not know who or where they are
11. Delusional	False belief not consistent with the reality of the patient's situation; e.g., belief by an indigent Medicaid resident that he has "a million dollars in the bank"
12. Hallucinates	False sensory perception in the absence of an actual external stimulus; may affect any of the senses; e.g., hearing voices when no one is talking
13. Emotionally labile	Exhibiting rapidly shifting emotions, frequently without apparent cause; e.g., shifting from depression to joy in a short period of time
14. Depressed	An unhealthy condition of emotional dejection and withdrawal, sadness greater and more prolonged than the situation seems to warrant
15. Inappropriate behavior, other	Describes a behavior pattern that is manifested by acts detrimental to the life, comfort, and/or property of himself and/or others

PATIENT CARE

A. Special Procedures

General Information

PATIENT CARE. These Sections describe treatments or procedures presently provided to an individual, in addition to his regular personal care, as well as visits by professionals in connection with his care. They also record medications being administered as of a given day.

Sources of Information
Patient's Medical Record
Nursing Notes
Physician's Order Sheet
Professional Consultant's Order Sheet

A. *Special Procedures.* (A. 1-38), identify special nursing, rehabilitative and restorative, teaching, or psychological procedures, or treatments.

Instructions

For each special procedure being applied at the time of this appraisal, place a check mark to the left of the procedure. On the right, write in both the frequency and the department or staff person who is presently performing it.

Definitions

A. Special Procedures	Treatment, or procedures, provided or supervised by licensed nursing personnel or special therapists, that are in addition to the provision of personal care services
Frequency	Number of times per hour, day, week, month, etc. treatment is given
By Whom	Identify discipline(s) of staff care giver(s)
GENERAL NURSING CARE	All treatments, procedures not included in "Human Help" under Activities of Daily Living
1. Preventive Skin Care	Procedures carried out to prevent infection, irritation, drying out of skin, etc.
2. Decubitus Care	Procedures carried out to treat decubitus ulcers in order to promote healing, e.g., Hydrogen Peroxide wash, an ointment.
3. Sterile Protective Dressings	The material applied to a wound for the purpose of promoting a healing process, for exclusion of air or for the absorption of drainage. Record site
4. Turning Schedule or Repositioning	A routine established for turning the patient on a regular schedule to prevent undue pressure, decubitus ulcers, or contractures
5. Oxygen Rx	The administration of oxygen by means of a nasal catheter, mask, or oxygen tent, etc. Indicate route of administration
6. Inhalation IPPB	The administration of Oxygen, or gases with or without medications under intermittent positive pressure
7. Suctioning	The process by which fluid or air is withdrawn from the body cavities
8. Irrigation - Bladder	The introduction of fluid into the urinary bladder, washing it out with fluid and draining it, usually via a catheter
9. Irrigation - Other than Bladder	The introduction and draining of fluid from a part of the body other than through a catheter into the urinary bladder. Indicate site
10. Ostomy Care	Care of an artificial opening from an internal hollow organ to the outer surface of the body. Record type
11. Enemas	Injection of water, either plain or containing medications into the rectum and colon in

	order to empty the lower intestine or to introduce food or medicine for therapeutic purpose
12. Hydrotherapy (e.g., whirlpool baths, soaks)	The application of water in any form, externally in the treatment of disease
13. Maintenance Ambulation	Ambulation for the purpose of preserving functional status of mobility
14. Restraints	Appliances used to prevent the patient from injuring himself or others. Includes restraints such as security suit, body holder, etc. (Chemical restraints are recorded in the medications section)
15. Other (specify)	Any special nursing procedure not otherwise listed in 1-14 above. Write in type, record frequency and by whom given, e.g., Time control bladder once every 2 hours by nurse's aide
REHABILITATION/RESTORATIVE	Special skilled care whose purpose is to raise the patient to, or maintain him at, his highest level of function. Such procedures follow a planned and written schedule
16. Speech Pathology	Includes patient appraisal of speech, voice, and language competencies, through standardized and other tests, to determine the need for and types of rehabilitation required; planning and conducting treatment programs, on an individual or group basis, to develop, restore or improve communicative efficiency of persons disabled in the processes of speech, voice; and/or language, and continuing evaluation and periodic revaluation, including both standardized and informal procedures to monitor progress and verify current status.
Audiology	Includes audiologic assessment (including basic audiometric testing and screening, examination for site of lesion, nonorganic hearing loss, and various parameters of auditory processing abilities essential for communication function); hearing aid evaluation; selection, orientation, adjustment and other technical related services; and audiologic habilitation and rehabilitation including the development, remediation or conservation of receptive and expressive language abilities.

17. Bowel Training	A program designed to help the patient restore control of bowel function
18. Bladder Training	A program designed to help the patient restore control of bladder function
19. Passive Exercises	Exercises done with assistance from another person in which the patient does not voluntarily use his own muscles. Specify location
20. Transfer Skills Training	Training that facilitates the patient in moving from one surface to another, e.g., bed to chair, wheelchair to toilet, chair to wheelchair, etc.
21. Active Exercises	Exercises by the patient done with or without resistance and with no assistance. Their purpose is to improve or maintain muscle strength and to reduce joint limitations. Specify location
22. Resistive Weight Lifting Exercises	The use of weight to resist the motion of a body part. Specify location
23. Gait Training	A program designed to help the patient improve the manner in which he walks
24. Prosthetic Training	A program designed to help the patient use his prosthesis functionally
25. Other (specify)	The name of other procedures not listed in 16-24 above. Indicate frequency and by whom given
TEACHING	A written, planned program of instruction for the patient, or his/her caretaker in specific procedures or treatments with the goal of self care or care by the individual taught
26. Diet Instructions	Instruction provided to a patient about a prescribed diet, including allowable types of amounts of food, beverages, and spices
27. Ostomy Care (Type)	Teaching a patient about care of his ostomy. Includes teaching of hygiene, how to clean, and take care of any special equipment
28. Foot Care	Teaching a patient about giving special attention to the feet. Teaching includes: 1) principles of basic hygiene; 2) attention to the condition of the skin; 3) avoidance of external risks such as ill fitting shoes, improper nail cutting or circulatory disruptions

29. Self Injection	Teaching a patient about the introduction of a medicinal substance or nutrient material, in fluid form, into the subcutaneous cellular tissue or muscular tissue
30. Other (specify)	Teaching a patient about procedures not listed under 26-29 above

PSYCHOSOCIAL

31. Self-directed Activities	Any activity selected by the patient according to personal preference, e.g., reading knitting, sewing, whittling, etc.
32. Group Activities	Ongoing programs, and specifically scheduled activities, designed for groups of patients for social and diversional purposes, e.g., arts and crafts, bingo, shopping tours, etc.
33. Religious Activities	Organized services for patients conducted according to religious beliefs. These include visits to a patient by a clergyman
34. Reality Orientatation Therapy	Planned small group activities, designed to provide therapy by stimulating awareness of the patient's physical, mental, and psychosocial environment
35. Remotivation Therapy	Planned small group activities, designed to provide therapy by stimulating awareness of the patient's physical, mental, and psychosocial environment
36. Behavior Modification Therapy	Therapy designed to use positive reinforcements to change a patient's behavior to a desired mode
37. Social Counseling	Direct service by a social worker to a patient and his family or caretaker, to work out the solution for a particular problem or to establish future plans
38. Other (specify)	Any other procedures, activities, or teaching programs of a psychosocial nature, not listed in 31-37 above.

General Information

B. Professional Visits (Q. B1-B8) identify the professionals who have provided specialized health care services to the patient. Dates indicate when such care was provided.

Instructions

Professional Visits (Q.B) requires a check mark for either the yes or the no category. If the response is *no*, go on to Section C, *Medications*. If *yes*, indicate by check mark the visiting professional and record the date or dates on which every visit was made.

B. Professional Visits	Visits made to the patient by the attending professionals
1. Attending Physician	Visit(s) by the physician (M.D. or D.O.) responsible for specifying primary medical care to the patient
2. Consultant Physician	Visit(s) to the patient by a physician (M.D. or D.O.) for the sole purpose of consultation with the attending physician
3. Dentist	Visit(s) to provide dental care to the patient
4. Optometrist/Ophthalmologist	Visit(s) to provide consultation and/or testing for visual problems
5. Speech Pathologist/Audiologist	Visit(s) to provide consultation and/or testing for speech and hearing problems
6. Psychologist	Visit(s) to provide psychologic consultation, testing, and counseling services
7. Podiatrist	Visit(s) to provide podiatry (foot care)
8. Other	Any other visit(s) not listed in 1-7 above, e.g., nurse practitioner, physician assistant, etc.
C. Medications	

General Information

Guided by the facility's pharmacist, this sample page provides space for the appraiser to analyze the type and pattern of medications actually being given to the patient on a given day, prior to each subsequent physician's visit.

This page is designed to indicate the medications and the usual pattern of medications that the patient received in a 24-hour period. The source of information would be from a Medication Administration Record or Nurse's Notes in the patient's record.

It should be remembered that the intent of this summary is not to duplicate the pharmacist's record of drug regimen review. His review and recommendations should be used as one of the important sources of information in the overall appraisal process. In close collaboration with the pharmacist, this page can be designed to supplement or serve as a pharmacist's patient drug profile. In summary, it is essential that the pharmacist review the patient's drug regimen, and the results of this review should be included in patient care appraisal and planning

Instructions

The analysis of medications administered should be done whenever a complete appraisal is conducted and when medications are identified in the care plan as being important to the achievement of goals.

If two or more medications are in the same category, identify each one by frequency and route and count separately.

If a medication is given by two routes of administration, e.g. IM *and* p.o., identify each one and count as two medications.

If the same medication is given in different strengths, e.g., Insulin NPH U100 40 units and 10 units, or Darvon 65 mg. and 32 mg., count only once.

If two types of the same medication are given, e.g., Insulin NPH U100 *and* Insulin Lente U50, identify each and count as two medications.

Indicate the total number of drug prescriptions given to the patient. Write the total below in the space indicated, and record the date of the appraisal review. This sum should only be included if it is determined to have administrative value, i.e., useful to the pharmacist as a part of a drug profile.

Definitions

Day chosen for review	A 24-hour period of time from 12:01 AM to 12:00 midnight.
Medications given	This includes both regular and p.r.n. drugs and that are brought to the patient. In the case of a p.r.n. medication that was not given that day would not be counted. If a p.r.n. medication is left at the bedside and the patient decides the frequency of use and/or dosage, determine from him/her how many times it was used that day and indicate route of administration as *self.*
Drug Category	See Appendix B—Drug Classification Guide
Side Effects	Unwanted effects of medicines, which originate from the known and desired pharmacologic action of the medicine. Some persons are more susceptible to them than are other persons.
Drug Allergic Reaction	An altered reaction of body tissues to a specific drug which in non-sensitive persons will, in similar amounts, produce no effect.
Drug Interaction	The phenomenon which occurs when the action of one drug is modified by the prior or concurrent administration of another (or the same) drug.
Food/Drug Interactions	The impairment of absorption and utilization of nutrients by drugs or the alteration of drug absorption and response by a food.
Drug Dependence	The result of adaptation of the body to a drug so that if the concentration of the drug falls below a certain level, the body is unable to function properly.

SELECTED READING RESOURCES

The following are sources of information on the topics listed: The HEW Long-Term Care Facility Improvement Program, Aging, Dental Care, In-Service Education, Management, Medical Care and Role of the Medical Director, Nursing Homes, Nurse Practitioners and Physician's Assistants, Nursing Home Administration, Nutritional Care, Patient Care in Long-Term Care, Pharmacy, Psycho-social Needs of the Aged, and Standards of Practice and Quality Assurance.

HEW Long-Term Care Facility Improvement Program

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5. *Assessing Health Care Needs in Skilled Nursing Facilities: Health Professional Perspectives.* Long-Term Care Facility Improvement Monograph No. 1, March 1976. 60 pp.
   Single copies will be sent on request from the Division of Long Term Care, Office of Standards and Certification, Health Standards and Quality Bureau, Health Care Financing Administration, HEW, Baltimore, Md., until the supply is exhausted
6. Chow, Rita K. "Assuring the Quality of Care: A Personal Perspective—From Tailoring to Outcome Measurement." *Nursing Leadership*, 1:11-22, September 1978, No. 2.
7. Chow, Rita K. "Development of a Patient Appraisal and Care Evaluation System for Long-Term Care." The *Journal of Long-Term Care Administration*, 5:21-27, Summer 1977, No. 2.
8. *How to Select a Nursing Home* is for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.
9. *Long Term Care Facility Improvement Study: Introductory Report*, July 1975, is available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402—Price $2.15 (Stock Number 017-001-00397-2). DHEW Publication No. (OS) 76-50021. 137 pp.
10. Multi-media presentation of color 35 mm. slides synchronized with a narration recorded on an audio tape cassette entitled, "Dimensions of Care;" the sound-slide program is available on loan from each of the 10 HEW Directors of the Regional Offices of Health Standards and Quality.
11. *Physicians' Drug Prescribing Patterns in Skilled Nursing Facilities.* Long Term Care Facility Improvement Monograph No. 2., June 1976, is available from the Superintendent of Documents. Price $1.25. No. (OS) 76-50050. (Stock No. 017-000-00173-6).

Direct Source—Long Term Health Care Information

1. Long Term Care Information: National Health Planning Information Center, Long Term Care Component, P.O. Box 1600, Prince George's Plaza, Hyattsville, Md. 20788. (Phone 301-927-6410, 8:30-5 PM Eastern Time, Mon.-Fri.)
   Information Resource for Long-Term Care Providers, professionals, associations, organizations, and institutions; provides information services including announcement of relevant documents, computerized reference services, referral service to other information centers, reference facility and Health Resources News.

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APPENDIX A
Supplementary Classification and Definition of Providers

APPENDIX A

Supplementary Classification and Definition of Providers

INSTITUTIONAL FACILITIES

01) General Hospital	An establishment that provides through an organized medical or professional staff and permanent facilities that include six or more inpatient beds—medical services; continuous nursing services; diagnosis and treatment, both surgical and nonsurgical—for patients who have any of a variety of medical conditions.
Specialty Hospitals	An establishment that provides through an organized medical or professional staff and permanent facilities that include six or more inpatient beds—medical services; continuous nursing services; diagnosis and treatment, both surgical and nonsurgical—for patients who have specified medical conditions or for other special categories of patients.
02) Psychiatric	
03) Geriatric	
04) Chronic Disease Includes tuberculosis	
05) Physical Rehabilitation	
06) Chemical and Substance Abuse	
07) Other	
Nursing Homes	An establishment with three or more beds whose primary function is to serve unrelated persons who do not need hospitalization but require skilled or limited nursing services and health-related services.
08) Skilled Nursing Facility (SNF)	A facility required by licensure to provide 24-hour a day skilled nursing care, or a facility that meets the Federal conditions of participation for a skilled nursing facility (SNF).
09) Intermediate Care Facility (ICF)	A facility licensed to provide supportive nursing care or a facility that meets the Federal conditions of participation for an intermediate care facility (ICF).
10) Combined SNF/ICF	Self-explanatory
11) Intermediate Care Facility for the Mentally Retarded (ICF/MR)	A facility licensed to provide supportive nursing care, or a facility that meets the Federal conditions of participation for an intermediate care facility for individuals with a condition of arrested or incomplete development of the mind, which is especially characterized by subnormality of intelligence.
Residential Care Facility	An establishment that provides—through permanent facilities that include three or more resident beds—primarily health-related services that may include limited nursing services to persons whose primary purpose of residence is not medical or nursing care. Health-related services are those services, other than

	medical, that are performed by qualified personnel and pertain to protective, rehabilitative, habilitative, educational, personal, and social services, to socialization activities, and to assistance with the activities of daily living.
12) Long-Term Residential Care Facility	An establishment whose primary purpose is to provide care and supervision in a supportive environment to residents who are elderly and/or have a special problem or condition. Although treatment is not often provided through the facility's staff, access to treatment is provided. Length of stay in such facilities is usually more than one year. Includes personal care homes for the elderly, homes for the severely handicapped, homes for mentally retarded children and adults.
13) Residential School and/or Treatment Center	An establishment that provides primarily through its own facilities and staff health-related services to residents of any age with one or more special problems or conditions. Includes schools for the mentally retarded, deaf, blind, physically handicapped, neurologically impaired, etc.; detoxification centers for chemical substance abusers; residential treatment facilities for emotionally disturbed children.
14) Transitional Residential Care Facility	An establishment that provides social support and guidance but not treatment to persons in an aftercare or post hospitalization status, or to persons admitted directly from the community, with the objective of helping them return to or achieve independent living. Length of stay is usually less than one year. Includes halfway houses for alcoholics, community residences for persons released from psychiatric facilities, residences for battered wives and their children.
15) Hospice	Organized program, usually in an inpatient facility which may or may not provide home care for support of the terminally ill patient and his family.

NON-INSTITUTIONAL SERVICES

16) Mental Health Clinic/Community Mental Health Center	A facility established primarily for the provision of out-patient mental health services.
17) Day Care Center	Public agency or private organization for non-residential clients that provides restorative, maintenance, or social programs in specially organized ambulatory setting.
18) Day Hospital	Similar to Item 17 but usually located in an inpatient facility and provides a greater intensity of care for up to 12 hours/day.
19) Home Health Agency or Unit	Public agency or private organization or subdivision of such an agency or organization that provides skilled nursing services, other therapeutic and special services delivered to the patient's residence.
20) Homemaker Agency or Unit	Public agency or private organization or subsdivision of such an agency or organization that provides supportive services such as homemaker/home health aide service to patients in need of such service in their place of residence.

21) General Ambulatory Care Service	Facility or provider for non residential patients with any of a variety of conditions or problems, both acute and chronic. Includes private physicians, clinics, group practices, hospital outpatient departments, community health centers, etc.
22) Sheltered Employment Program	
23) Special Education Day Program	
24) Coordination/Counseling Referral Program	
25) Other	Any other regular sources of care that have not been identified above.
26) Self or Family Care/No Reg Provider	Services or needs are not supplied by any of the above providers.

APPENDIX B
Drug Classification Guide

Drug Classification Guide

The following definitions are provided as a helpful reference for classifying the drug prescriptions for detailed analysis. Examples for each category are usually listed by generic name, but trade names are used as well when they are more descriptive.

These 30 categories were arrived at through analysis of data on drug prescribing patterns for 283,914 patients in skilled nursing facilities. There were 1,731,360 drug prescriptions that underwent data analysis. To achieve consistent categorization of drugs and uniformity of analysis, a standard drug dictionary was prepared from the prescriptions surveyed. The drugs that seem to belong to more than one category were placed according to the definitions in the section of more common usage. For example, Mycolog Cream will fit into either of three categories: anti-infectives, adrenal cortical hormones, or skin/mucous membrane preparations. But, by definition, *all* preparations applied to the skin would be included in the latter category. Therefore, Mycolog Cream was placed in the section titled "Skin and Mucous Membranes."

Details of the methodology are described in the Department of Health, Education, and Welfare's publication on the Long Term Care Facility Improvement Campaign's Monograph No. 2 entitled: *Physicians' Drug Prescribing Patterns in Skilled Nursing Facilities,* that was published in June 1976 (GPO Stock Number 017-000-00173-6).

In order to evaluate patient care concerning drug therapy, drugs should be categorized according to therapeutic action to the extent possible. Most of the categories that are numbered 1 to 30 and listed in alphabetical order, can be associated with some therapeutic action. The two exceptions are Eye, Ear, Nose, and Throat (EENT) Preparations (19) and Skin/Mucous Membranes (23). Narcotic Analgesics (21) can be given special attention by being placed in a separate category and, therefore, should not be included under Analgesics (2).

The categories in this Appendix have been devised to assist the PACE appraiser in care assessment. For example, Schedule II drugs that come under the Controlled Substances Act may be placed in an appropriate subclass of:

- Narcotic Analgesics
- Sedatives/Hypnotics, or
- Stimulants

In review, the Controlled Substances Act requires the registration of persons who manufacture, distribute, prescribe, administer, or dispense any Controlled Substance. It requires accurate records and inventories of drugs purchased, distributed, and dispensed by all persons involved in the legitimate handling of Controlled Substances. Under Schedule II of the Controlled Substances Act, specified drugs (including amphetamines and methamphetamines) are considered Controlled Substances if:

A. The drug or other substance has a high potential for abuse;

B. The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; or

C. Abuse of the drug or other substance may lead to severe psychological or physical dependence.

All prescriptions for drugs listed in Schedule II must be in writing, and no prescription can be refilled. Emergency telephone prescriptions for drugs in this schedule may be filled if the practitioner furnishes a written, signed prescription to the pharmacy within 72 hours. The amount of the drug on such a prescription must be limited to the amount needed to treat the patient during the emergency period. If the written prescription has not been received by the pharmacist within 72 hours, the pharmacist must notify the Drug Enforcement Agency (DEA) in the Department of Justice Regional Offices.

1. ADRENAL CORTICAL HORMONES AND RELATED SUBSTANCES

Hormones or steroids naturally occurring either as an organic product of the adrenal glands or synthetically derived. They restrain allergic and inflammatory mechanisms. The restraining action of these agents is especially valuable in diseases characterized by excessive inflammatory reaction and those in which the symptoms and permanent effects are largely the result of reactions to disease rather than the effect of the biologic agent itself; for example, rheumatoid arthritis, collagen diseases, eye inflammations, and allergies. Important drugs in this field are the synthetic derivatives of the naturally occurring adrenocortical steroids (hydrocortisone, dexamethasone). Drugs in this category include:

Prednisone
Prednisolone
Dexamethasone
Hydrocortisone
Corticotropin (ACTH) or its alternate forms, e.g.,
  Corticotropin G
Methylprednisolone

Exclusions

Because of their particular dosage form, corticosteroids that are intended for use in the eyes, ears, nose, and throat or for the skin and mucous membranes are so classified and are not included in this category.

2. ANALGESICS

Drugs that relieve or alleviate pain by systemic action. These include:

Aspirin

Propoxyphene or its alternate forms, e.g.,
- Propoxyphene Hydrochloride
- Propoxyphene Napsylate

Acetaminophen

Exclusions

Narcotic Analgesics which are classified as Controlled Substances, Schedule II (codeine, morphine) are not included in this category and should be listed under No. 21 Narcotic Analgesics (Controlled Substances). Analgesic drugs administered by application to skin and mucous membranes, such as Ben-Gay, Preparation H, also are excluded from this category.

3. ANTACIDS

Drugs which combine with or neutralize acids of the stomach. These include:

Aluminum Hydroxide and/or Magnesium Hydroxide—Include prescriptions for Magaldrate (Magal-drate) and its other forms, e.g.,
- Aluminum Hydroxide
- Magnesium Hydroxide

4. ANTICOAGULANTS

Drugs which inhibit the blood clotting mechanism. These include:

Warfarin and its alternate form, e.g.,
- Warfarin Sodium

Heparin

Warfarin and related agents are also used to prevent intravascular blood clotting in the treatment of such conditions as coronary infarction and thrombophlebitis.

5. ANTICONVULSANTS

Drugs or agents that prevent or relieve violent involuntary muscle contractions, and used in the treatment of epilepsy. Two examples are:

Phenytoin
Primidone

6. ANTIDEPRESSANTS

Agents used in treatment of depression to prevent or alleviate the depressed state. Examples include:

Amitriptyline
Imipramine
Perphenazine
Doxepin
Lithium Carbonate

7. ANTIDIARRHEALS

Agents that are effective in combating diarrhea (abnormal frequency and liquidity of fecal discharges). Examples are:

Diphenoxylate
Kaolin/Pectin
Opium and its various forms, e.g.,
- Opium Tincture
- Opium and Belladonna

Hyoscyamine Sulfate
Paregoric and its alternate forms, e.g.,
- Bismuth Paregoric

8. ANTIHISTAMINES

Drugs that antagonize the effects of histamine and relieve allergic reactions. Examples are:

Diphenhydramine
Promethazine
Chlorpheniramine and its alternate form, e.g.,
- Chlorpheniramine Maleate

Brompheniramine Maleate
Trimeprazine Tartrate
Cyproheptadine
Triprolodine

Exclusions

Examples of antihistaminic drugs not found in this section include agents used for motion sickness, dimenhydrinate (Dramamine), agents found in expectorants and cough preparations such as diphenhydramine hydrochloride (Benadryl Elixir, Benylin Cough Syrup) and promethazine hydrochloride (Phenergan expectorant), and those antihistamines which, because of their particular dosage form, are applied to the skin and mucous membranes.

9. ANTIHYPERTENSIVES

Agents (hypotensors) that counteract hypertension by lowering the blood pressure. Examples are:

Methyldopa
Reserpine
Rauwolfia in its various forms, e.g.,
- Rauwolfia—Whole Root
- Rauwolfia Serpentina

Exclusions

The thiazides (Diuril, Hydrodiuril) that exhibit hypotensive action with or without edema are not included in this category but appear in the category Diuretics (No. 15), instead.

10. ANTI-INFECTIVES

Drugs used to control infections. These would include antibacterial, antifungal, and antiviral agents:

Methenamine or its alternate forms, e.g.,
  Methenamine Mandelate
  Methenamine Hippurate
Sulfisoxazole
Nitrofurantoin
Ampicillin
Tetracycline
Cephalexin Monohydrate
Sulfamethoxazole
Penicillin or its alternate forms, e.g.,
  Penicillin G
  Procaine Pencillin
  Procaine Penicillin G
Erythromycin or its alternate form, e.g.,
  Erythromycin Stearate

Exclusions

Anti-infective products intended for use in the eye, ear, nose, and throat or for the skin and mucous membranes (vaginal tablets or creams) are not included in this section.

11. ANTI-PARKINSONISM AGENTS

Drugs used to relieve or control some of the symptoms of Parkinsonism, such as muscle rigidity and/or tremor. Some examples are:

Trihexyphenidyl
Benztropine Mesylate
Levodopa
Procyclidine Hydrochloride

12. BRONCHODILATORS

Drugs that cause luminal expansion of the air passages of the lungs. Products designed for inhalation therapy, if they contain a bronchodilator, will also be found in this category. Examples are:

Theophylline
Aminophylline
Oxtriphylline
Ephedrine or its alternate form, e.g.,
  Ephedrine Sulfate
Isoproterenol
Hydroxyzine
Pseudoephedrine
Acetylcysteine

13. CARDIAC DRUGS

Agents that increase the force of myocardial contractions and/or affect the heart rate, rhythm or conduction; prevent or reduce the pain of angina pectoris; and increase heart action by stimulation. These include:

Digoxin
Nitroglycerin
Digitoxin
Isosorbide Dinitrate
Procainamide

14. CATHARTICS

Cathartics, purgatives, physics, evacuants, and like drugs differ only in the intensity of their effect on the bowel, but the effect itself is more or less the same: the bowel is evacuated by distending or irritating it. Also included in this category are fecal softeners since these agents aid in the evacuation of the bowel. Examples are:

Magnesium Hydroxide
Dioctyl Sodium Sulfosuccinate
Bisacodyl
Danthron
Cascara Sagrada
Dioctyl Calcium Sulfosuccinate
Sodium Biphosphate
Senna Concentrate

15. DIURETICS

Drugs which increase the rate of urine formation. These include:

Furosemide
Triamterine
Chlorothiazide
Chlorthalidone (e.g., Hygroton)
Hydrochlorothiazide
Spironolactone
Acetazolamide

Such thiazides as chlorothiazide (Diuril) and hydrochlorothiazide (Hydrodiuril) are found in this section, even though they have both a diuretic effect and a hypotensive effect. These diuretic antihypertensives reduce blood volume, cardiac output, and may dilate blood vessels.

16. ELECTROLYTE AND FLUID REPLACEMENTS

The various salts (for example, sodium, calcium, potassium) which are dissolved in the blood plasma and are necessary for homeostasis. Preparations may be in solution form and contribute fluid, mixed electrolytes, sodium chloride, potassium, and acidity or alkalinity. Examples are:

Ammonium Chloride solution

Blood and derivatives, e.g., human plasma
Blood substitutes, e.g., Dextran
Calcium Chloride
Potassium Chloride
Potassium Gluconate
Sodium Bicarbonate, e.g., 5% solution
Sodium Chloride, e.g., physiological saline
Sodium Lactate, e.g., Sodium Lactate 1/6 M
Tromethamine

17. ESTROGENS/ANDROGENS

Female sex hormones and male sex hormones that are important body regulators. These hormones are administered when a clear diagnosis of insufficiency exists and are used also in the treatment of certain disease states. For example, cancer of the prostate in the male and cancer of the breast in the female may be responsive to surgical removal and subsequent treatment with the sex hormones. Examples are:

Estrogens
Diethylstilbestrol
Methyltestosterone
Methandrostenolone
Ethinyl Estradiol
Estrone

18. EXPECTORANTS/COUGH PREPARATIONS

Agents that promote the ejection of mucous or exudate from the lungs, bronchi, and trachea. Expectorants are used in instances in which the cough is nonproductive or in which the mucous is so tenacious as to make its removal especially difficult or painful. Cough suppressants, such as codeine or dextromethorphan, are used in cases in which cough causes serious distress, for example, in pneumonia and bronchitis. Examples are:

Dextromethorphan hydrobromide (e.g., Dimacol)
Diphenhydramine hydrochloride elixir or expectorant
Glyceryl Guaiacolate (e.g., Chlor-Trimeton Expectorant, Dimetame Expectorant-DC, Robitussin, Tedral Expectorant, Triaminic Expectorant)
Promethazine (e.g., Phenergan Expectorant)
Terpin Hydrate

Exclusion

Codeine should be categorized under Narcotic Analgesics (Controlled Substances).

19. EYE/EAR/NOSE/THROAT (EENT) PREPARATIONS

Drugs that include: (1) those used for a specific purpose in the treatment of particular condition in the sense organ or body part, for example, (a) miotics to constrict the pupil of the eye or to treat glaucoma, and (b) the use of medication for the easy removal of earwax from the external acoustic meatus; and (2) those for a more general use, such as, decongestants for the reduction of swelling of the nasal and nasopharyngeal mucosa. Examples are:

Pilocarpine or its alternate forms, e.g.,
  Pilocarpine Hydrochloride
  Pilocarpine Nitrate
Polymyxin-B
Hydrocortisone (includes ophthalmic preparations)
Cocaine
Dexamethasone
Sulfacetamide or its alternate form, e.g.,
  Sodium Sulfacetamide
Prednisolone
Tetrahydrazoline
Methylcellulose
Phenylephrine

20. INSULIN/ANTIDIABETIC AGENTS

Insulin, a preparation of the active principle of the pancreas, is used therapeutically in diabetes. Antidiabetic agents—the oral hypoglycemic drugs—alleviate diabetes by stimulating the pancreas to release insulin into the bloodstream. These drugs include:

Insulin
Tolbutamide
Chlorpropamide
Phenformin
Tolazamide
Acetohexamide

21. NARCOTIC ANALGESICS (CONTROLLED SUBSTANCES)—Schedule II

Drugs that relieve or alleviate pain by systemic action; drugs that should be included are those formerly known as "Class A Narcotics." Representative drugs, including some brand names and manufacturers, are:

Codeine
Hydromorphone (Dilaudid, Knoll)
Meperidine HCl (Demerol, Winthrop)
Meperidine HCl and Promethazine HCl (Mepergan, Wyeth)
Methadone (Dolophine, Lilly)
Morphine
Oxycodone, A.P.C. (Percodan, Endo)

Exclusions

Other Controlled Substances will be found under Sedatives/Hypnotics and Stimulants. Opium, e.g., paregoric, is classified under antidiarrheal. Cocaine that is used for topical anesthesia in the eye, nose, and throat should be placed in category 19—EENT Preparations.

22. SEDATIVES/HYPNOTICS

Sedatives are drugs used to relieve anxiety and to ease tension states. Hypnotics are drugs that act to induce sleep.

Chloral in its various forms, e.g.,
  Chloral Hydrate
  Chloral Betaine
Flurazepam
Phenobarbital
Glutethimide
Ethchlorvynol

Controlled Substances:

Methaqualone

The barbiturate derivatives (e.g., amobarbital) classified as Schedule II controlled substances included in this section are:

Pentobarbital or its alternate form, e.g.,
  Pentobarbital Sodium
Secobarbital

23. SKIN/MUCOUS MEMBRANE

Drugs used in the treatment of conditions of the skin and mucous membrane including antibiotics, topical steroids, antiseptics, and similar agents in a cream, ointment or other base for ease of use for relief of symptoms or treatment of disease(s). Some examples are (1) the application of topical steroids for the treatment of contact dermatitis or pruritus acne; and (2) povidone-iodine used as a mild anti-infective agent on a cut or abrasion. These drugs include:

Polymyxin B
Triamcinolone
Hydrocortisone (includes ointments and creams for topical application)
Vitamins A & D
Betamethasone or its alternate form, e.g.,
  Betamethasone Valerate
Fluocinolone
Povidone-Iodine
Iodochlorhydroxyquin

24. SPASMOLYTICS (ANTISPASMODICS)

Drugs used to relieve spasms of smooth muscle in such organs as the urinary tract and the gastrointestinal tract. Many of the drugs included in this category are combination products which include the spasmolytic agent plus a digestive enzyme or a sedative or an agent to absorb stomach gases. Examples are:

Hyoscyamine or its alternate form, e.g.,
  Hyoscyamine Sulfate
Dicyclomine
Propantheline
Flavoxate
Isopropamide
Atropine

Exclusion

Phenobarbital should be classified under Sedatives/Hypnotics even though it may be used as an antispasmodic.

25. STIMULANTS

Agents that arouse organic activity increasing vitality. This classification includes drugs employed as an analeptic (a lessening of the depression) such as:

Pentylenetetrazol

Controlled Substances: Other stimulants that are Schedule II Controlled Substances but should be classified in this section include:

Amphetamine sulfate
Amphetamine Sulfate, Aspirin and Phenacetin
Amphetamine and dextroamphetamines
Dextroamphetamine sulfate
Dextroamphetamine sulfate and amobarbital
Dextroamphetamine sulfate and meprobamate
Dextroamphetamine sulfate and prochlorperazine
Methamphetamine HCl (Desoxyn, Abbot)
Methamphetamine HCl and sodium pentobarbital (Desbutal, Abbott)
Methamphetamine HCl, pentobarbital, ascorbic acid, sodium ascorbate, thiamine mononitrate riboflavin and niacin
Methamphetamine HCl and phenobarbital
Methylphenidate HCl (Ritalin, Ciba-Geigy)
Phenmetrazine HCl (Preludin)

26. THYROID REPLACEMENTS

Active hormones given to increase the metabolic rate of body tissue as replacement or substitution therapy in patients with diminished or absent thyroid function. They may be synthetics or obtained from animal sources. They include:

Thyroid Extracts
Levothyroxine or its alternate form, e.g.,
  Levothyroxine Sodium
Liotrix
Liothyronine
Thyroxine

27. TRANQUILIZERS

Drugs that act on the emotional state, quieting or calming an individual without affecting clarity of consciousness. Major tranquilizers are drugs that reduce psychotic symptoms; minor tranquilizers are used in the treatment of anxiety and tension or psychoneurosis. Examples are:

Thioridazine
Chlorpromazine
Diazepam
Prochlorperazine
Haloperidol

Hydroxyzine
Promazine or its alternate form, e.g.,
  Promazine Hydrochloride
Chlordiazepoxide

28. VASODILATING AGENTS

Drugs that cause dilation of the blood vessels, especially arterioles, leading to an increase in blood flow. Examples are:

Papaverine or its alternate form, e.g.,
  Papaverine Hydrochloride
Isoxsuprine
Cyclandelate
Nylidrin
Pentaerythritol Tetranitrate
Ethaverine Hydrochloride

29. VITAMINS/MINERALS

Essential nutrients for the normal metabolic functioning of the body. Standards for the daily requirements of the essential vitamins and minerals have been set and serve as the basis for prophylaxis or treatment in the prevention or cure of deficiencies. Included in this category are drugs closely related to vitamins, such as niacin and folic acid as well as vitamin-mineral combination products and iron preparations:

Multivitamin
Multivitamin B-Complex
Vitamin B-12
Vitamin C or its various combinations, e.g.,
  Vitamin C/Ferrous Fumarate
  Vitamins B & C
Nicotinic Acid or its various combinations, e.g.,
  Nicotinamide
  Nicotinic Acid Amide
Vitamin B-Complex
Folic Acid
Iron preparations in its various forms, e.g.,
  Ferrous Sulfate
  Ferrous Fumarate
  Ferrous Gluconate
  Ferrous Hydroxide
  Ferrocholinate

30. OTHER

This is a miscellaneous grouping of all drugs that do not fit into the previously described categories. Examples of products included here are: 1) anti-motion sickness agents; 2) ergot alkaloids; 3) ethyl alcohol; 4) nonsteroid anti-inflammatory agents; 5) vaccines; and 6) agents used to lower the uric acid blood level.

Anti-Motion Sickness Agents
  Diphenhydramine
  Meclizine
Ergot Alkaloids (e.g., Hydergine)
Ethyl Alcohol
Nonsteroid Anti-inflammatory Agents
  Indomethicin (Indocin)
  Naproxen (Naprosyn)
Vaccines
Xanthine Oxidase Inhibitors
  Allopurinol (Zyloprim)

APPENDIX C
Sample Case #1—Alice Abrams

APPENDIX C

Sample Case #1—Alice Abrams

Alice Abrams has diabetes, osteoarthritis, and a history of angina. On October 1, 1977, she is admitted into the facility with hopes that long-term care can relieve some of the problems that she is having with her arthritis.

On October 2, 1977, Mrs. Abrams' initial PCM Appraisal (1) is begun. The first appraisal notes that she has the following problems, impairments and dysfunctions (P/I/D):

History of angina
Apprehension, Antagonistic, Depression
Pain due to arthritis
Vision Impairment
Reduced ROM (hands, ankles, knees)
Diabetes (FBS 198 mgs%)
Diabetes (Intake Problem)

October 14, 1977: Mrs. Abrams' appraisal is completed. Appraisal I data are found on the following pages (AAI-15).

ALICE ABRAMS (AA Case #1)

OCTOBER 1, 1977
Mrs. Alice Abrams is admitted to the Long-Term Care (LTC) facility.

OCTOBER 2, 1977
Mrs. Abrams' initial PACT Appraisal (Appraisal I) is begun.

OCTOBER 14, 1977
Mrs. Abrams' appraisal (Appraisal I) is completed. Appraisal I data are found on the following pages (Case AA 4-16).

Alice Abrams
- Age 87
- Height 5' 5½"
- Weight 182 lbs.
- Marital Status widowed, no children
- Living Arrangements—lived alone in family home; has lived in community all her life.
- Racial/Ethnic Background—Negro
- Usual Occupation—at one time taught public school, more recently was a homemaker; gave 50 years of volunteer service to neighborhood church.

Background—Mrs. Abrams has lived alone in the family home since the death of her husband 10 years earlier. Prior to retirement, Mrs. Abrams was a public school teacher in Washington, D.C. She earned a decent retirement income from savings, social security, and her husband's retirement; however, some of her care in the home will be financed by Medicaid.

Presenting Problems—Mrs. Abrams is admitted to the long-term care facility because she can no longer take insulin unassisted and because she chooses not to live with her nephew on the other side of town. Another reason for entering the facility is her desire to be close to friends already in the home. Although she suffers from arthritis pain and swelling and has a history of heart trouble, she requires only supervisory care. Among the medications she takes are Darvon, Insulin Regular (U100), and Insulin NPH (U100). Mrs. Abrams wears a set of dentures and requires a special diet to control her diabetes. Everyone that knows Mrs. Abrams describes her as an alert, intelligent, independent person who likes to be active and gets a great deal of satisfaction from involvement in community service.

Mrs. Abrams was admitted to the long-term care facility by her doctor who believed her weakened physical condition required supervised health maintenance.

Physician's Orders
Physical Therapy daily for Arthritis also warm packs and soaks, and whirlpool
1200 Calorie A.D.A. diet
Darvon for pain
KCL 10cc t.i.d.
Lanoxin 0.25 m.g. q.d.
Dioctyl 1 tab. Daily
Insulin NPH U 100 40 units q.A.M. 10 units q.P.M.
D.C. Regular Insulin
Maalox 30 cc p.r.n. at bedside
Lasix 2 tab. q.d.
Aspirin Buffered 2 tab. p.r.n.
Nitroglycerin gr. 1/150 1 tab. Subling. p.r.n. at bedside
Valisone Cream locally p.r.n.
Quinidine Sulfate 1 or 2 tab. b.i.d.

PACE II INSTRUMENT

Case AA-4 Appraisal I

ADMISSION DATA

See Instructions pp. 43-47

1 Provider Identification _____
2 Patient Identification Number 000-000-000AA
3. Provider Location _____
4. Provider Type (Specify type) ICF
(See Supplementary Classification of Providers in Appendix A)

5. Date of Latest Admission to Provider ___/___/ NA
month day year
6. Date of First Admission to Provider 10 / 1 / 77
month day year
7. Date of Latest Discharge from Provider ___/___/___
month day year
8. Number of Prior Admission(s) to Provider _____
9. Last Principal Provider (Specify type) _____
(See Supplementary Classification of Providers)
10 Physician's Prognosis on Admission
Indicate below the attending physician's prognosis at the time of admission for the client:

☐ **No Change** ☐ **Improvement** ☐ **Deterioration** ☐ **Not Determined** ☐ **Has Discharge Potential (Use Schedule C)**

DEMOGRAPHIC DATA

1. Date of Birth 12 / 20 / 89
month day year
2. Sex: ☐ **Male** ☒ **Female**
3. Race/Ethnicity
a. Race.
☐ **American Indian or Alaskan Native** ☐ **Asian or Pacific Islander** ☒ **Black**
☐ **White** ☐ **Not Determined**
b. Ethnicity
☐ **Hispanic Origin** ☐ **Not of Hispanic Origin** ☐ **Not Determined**
4. Current Marital Status
☐ **Never Married** ☐ **Married** ☒ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Not Determined**
5 Usual Residence *(Type of residence in which the patient has been residing for the past six months. For clients continuously in an institutional setting for six months or more, the facility will be considered his/her residence.)*
☒ **Home/Apartment** ☐ **Rented Room, Commercial Hotel** ☐ **Supportive Housing** ☐ **Institutional Setting**
6 Residence/Location SE. WASHINGTON, D.C.

7. Usual Living Arrangement *(Check all that identify with whom the patient has been living during the past six months.)*
☒ **Lived Alone** ☐ **Lived with Spouse** ☐ **Lived with Family** ☐ **Lived with Others**
8. Court Ordered Constraints
a Is the client under court ordered care? ☒ **No** ☐ **Yes**
b. Does he/she have a court appointed guardian? ☐ **No** ☐ **Yes**

DISCHARGE DATA

(To be filled out only at the time of discharge from latest admission to provider.)

1. Discharge Date ___/___/___
month day year
2. Status on Discharge (Check most applicable)
☐ **Improved** ☐ **No Change** ☐ **Deteriorated** ☐ **Deceased**
3. Discharged to: (Specify type) _____
(See Supplementary Classification of Providers)

Case AA-5

MEDICAL DATA

SAMPLE

(Instructions on pp. 47-52)

Appraisal Number

1	2	3	4	5	6
☒	☐	☐	☐	☐	☐

A. Medically Defined Conditions

At the time of admission or first appraisal, record all medical conditions for which the client is actually receiving care by indicating with a check mark the single primary diagnosis and all secondary diagnoses as applicable. Write in the specific diagnoses in the last column.

DIAGNOSTIC CATEGORY	PRIM.	SEC.	SPECIFIC DIAGNOSES
Neoplasms			
Endocrine, Nutritional, Metabolic Diseases, and Immunity Disorders	✓		Diabetes
Diseases of Blood and Blood-forming Organs			
Organic Psychotic Conditions			
Other Psychoses			
Neurotic and Personality Disorders			
Mental Retardation, mild			
Mental Retardation, moderate			
Mental Retardation, severe			
Mental Retardation, profound			
Mental Retardation, unspecified level			
Diseases of the Nervous System and Sense Organs			
Stroke, including late effects			
Atherosclerosis			
Diseases of the Circulatory System other than Stroke and Atherosclerosis		✓	Heart Disease
Diseases of the Respiratory System			
Diseases of the Digestive System			
Diseases of the Genitourinary System			
Diseases of the Skin and Subcutaneous Tissue			
Diseases of the Musculoskeletal System and Connective Tissue		✓	Osteoarthritis
Congenital Anomalies			
Injury and Poisoning			
Symptoms, Signs, and Ill-defined Conditions			
Other diagnosis			
Unknown diagnosis			
No disease			

Schedule A should be used for subsequent appraisals if (1) a previously unrecognized condition is diagnosed and requires care, or (2) a previously recognized condition, that did not require care formerly, becomes active.

B. Medical Status Measurements

On the initial appraisal, record the results of the latest measurements and indicate the date on which the test was made. Any tests done or repeated at a later date should be recorded on Schedule A.

	TEST	DATE
1. Height	65 1/2 (inches)	10/4/77
2. Weight	182 (pounds)	"
3. Blood Pressure	150 (Systolic) / 86 (Diastolic)	"
4. Pulse Rate	72 (per minute)	"
5. Respiratory Rate	18 (per minute)	"
6. Blood Tests (Type of Test: ☐ Fasting ☐ Postprandial for Blood Sugar below)		
a. Blood Sugar	198 (mg. %)	"
b. Blood Urea Nitrogen	(mg. %)	"
c. Hemoglobin	11.6 (Gm.)	"
d. Hematocrit	(%)	"
7. Urine Tests (record as negative, trace, or one or more +'s)		
a. Albumin (Type)	Neg.	"
b. Sugar (Type)	++ tested 2x a day	
c. Acetone (Type)	Neg.	
8. Stool Test for Occult Blood (Type) (Record as negative, trace, or one or more +'s)		
9. Other, specify		

PATIENT APPRAISAL DATA

SAMPLE
See Instructions pp. 53-54

Case AA-6

Appraisal Number
1 2 3 4 5 6
☒ ☐ ☐ ☐ ☐ ☐

PATIENT ID NUMBER
☐☐☐☐☐☐☐☐

PACE APPRAISER: Jane Doe, R.N., Nursing
Name and Discipline

Beginning Date of Appraisal October 1, 1977

Type of Appraisal
☒ Admission/Initial ☐ Periodic
☐ Routine (Annual) ☐ Discharge
☐ Other (Specify) _____

1. Present Level of Care (Check appropriate box)
   - ☐ Skilled Nursing Care
   - ☒ Intermediate Care
   - ☐ Other (Specify) _____
2. Present Reimbursement Source(s). Indicate in the space provided whether (P) principal or (S) supplemental; (unless a change has occurred since last appraisal, omit this question).
   - _____ Medicare (Title XVIII)
   - S Medicaid (Title XIX)
   - _____ Social Services (Title XX)
   - _____ V.A.
   - _____ Workers' Compensation
   - _____ All Other Public Sources
   - P Blue Cross or Commercial Health Insurance
   - _____ Self Pay
   - _____ No Charge
   - _____ Not Determined
3. Have any incidents or accidents occurred involving this patient since the last appraisal?
   ☐ No ☐ Yes
   If yes, give details Not Applicable
4. Has there been a significant change in the individual's physical or emotional status since the last appraisal?
   ☐ No ☐ Yes
   If yes, give details Not Applicable For First Appraisal
5. Rehabilitation Potential:
   a. Is there a possibility of restoring the indivdual from his/her present physical and/or emotional functional level to a higher level of function? (check appropriate box)
      ☐ No ☒ Yes
   b. If yes, explain in what functional areas this is possible Psychological Adjustment to Facility
   c. If no, is there a possibility of preventing deterioration of the present physical and/or emotional state to sustain the individual's current capacities? (check appropriate box)
      ☐ No ☒ Yes
   d. If yes, specify the functional areas Perhaps hand function, through physical therapy, active and passive exercises.
   e. If no, is there a possibility of slowing down the process of deterioration? (check appropriate box)
      ☐ No ☒ Yes
   f. If yes, specify the functional areas Leg function through physical therapy, active and passive exercises
6. If improving, is discharge anticipated within one month?
   ☒ No ☐ Yes
   If yes, complete Schedule C.

Fill in this section at end of appraisal.
Check appropriate box(es) indicating the professional discipline of persons contributing to this appraisal:

- ☒ R.N.
- ☒ L.P.N.
- ☒ Aide/Orderly
- ☒ Other, specify Dietician, Activities Director
- ☒ Social Worker
- ☒ Physical Therapist
- ☐ Occupational Therapist

PACE Appraiser's signature Jane Doe, R.N.

Date of Completion of Appraisal: Oct. 13 1977
month day year

IMPAIRMENTS

Appraisal Number

1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER ☐☐☐☐☐☐☐☐☐

A. Skin

1. **Are there any decubitus ulcers present at this appraisal:** ☒ **No** ☐ **Yes**
   If yes, indicate number of sites _____
2. Are there any other skin abnormalities: ☒ **No** ☐ **Yes**

If Item 1 and/or 2 is answered yes, complete Schedule B.

B. Extremities and Trunk

Are there any missing limbs or fracture/dislocation of the hip or other bone: ☒ **No** ☐ **Yes**
If yes, complete the following chart.

EXTREMITY		MISSING LIMBS Date of amputation, and Type: (BE) Below Elbow (AK) Above Knee (AE) Above Elbow (P) Prosthesis (BK) Below Knee	FRACTURED HIP(S) Date of Repair (R) or Prosthesis	OTHER FRACTURES/ DISLOCATIONS Date and Location
UPPER	R			
	L			
LOWER	R			
	L			

C. Sensory/Communication Status (check appropriate box(es))

1. Vision (with glasses if customarily used)
   ☐ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
   ☒ b. **Moderate loss** ☐ **d. Total blindness**
2. Hearing (with hearing aid if customarily used)
   ☒ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
   ☐ **b. Moderate loss** ☐ **d. Total deafness**
3. Expressive Communication
   Select the one category that best describes the **usual** method used by the patient in conveying information.
   ☒ **a. Speaks and is usually understood** ☐ **d. Uses gestures, grunts, or primitive symbols**
   ☐ **b. Speaks but is understood only with difficulty** ☐ **e. Does not convey needs**
   ☐ **c. Uses structured sign language, symbol board, or writes** ☐ **f. Not determined**
4. Receptive Communication
   Select the one category that best describes the patient's **usual** method of understanding information conveyed by others.
   ☒ **a. Hears and usually understands** ☐ **e. Does not understand**
   ☐ **b. Hears and understands only with difficulty** ☐ **f. Not determined**
   ☐ **c. Depends on lip reading, written materials, or structured sign language**
   ☐ **d. Understands only primitive gestures, facial expressions or simple pictograms and/or recognizes environmental cues**

D. Bowel/Bladder Status

1. Is there bowel incontinence:
   ☒ **No** ☐ **Yes**
   If yes, specify frequency of incidents _____
2. Are there any other bowel problems such as ostomy:
   ☒ **No** ☐ **Yes**
   If yes, specify _____
   If yes, is assistance needed? ☐ **No** ☐ **Yes**
3. Is there bladder incontinence:
   ☒ **No** ☐ **Yes**
   If yes, specify frequency of incidents _____
4. Are there any other bladder problems such as ostomy, indwelling catheter or external device:
   ☒ **No** ☐ **Yes**
   If yes, specify _____
   If yes, is assistance needed? ☐ **No** ☐ **Yes**

Appraisal Number

1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Note—During any of the specified tests in Section A—Range of Motion and Section B—Strength, Balance, and Coordination, if the client indicates pain on motion, stop that portion of the test immediately. Proceed to another test. If tests in these sections are medically contraindicated, give reasons:

_____ **Date** ___/___/___

_____ **Date** ___/___/___

A. Range of Motion

With patient lying on back on bed, test passive movements of upper and lower extremities for full range of motion. Indicate by check in the chart below if there is restriction and/or disabling condition in any extremity. Specify other observations in the space provided.

PARTS OF THE BODY	RESTRICTED					OTHER OBSERVATIONS
	FLEXION A	EXTENSION B	ABDUCTION C	ADDUCTION D	ROTATION E	F.
1. Right Extremities						
a. Fingers/Thumb						
b. Wrist						
c. Elbow						
d. Shoulder						
e. Ankle	✓	✓				Impaired, Pain, Limited Motion
f. Knee						
g. Hip						
2. Left Extremities						
a. Fingers/Thumb						
b. Wrist						
c. Elbow						
d. Shoulder						
e. Ankle	✓	✓				Impaired, Pain, Limited Motion
f. Knee	✓	✓				" " " "
g. Hip						

3. Head and Trunk

With patient sitting unsupported on side of bed, test range of motion of head and trunk. If patient cannot sit unsupported on side of bed for any reason, indicate in the margin that the test was not done. If appropriate, complete test at a later date.

Is there any restriction and/or disabling condition in head or trunk?

☑ **No** ☐ **Yes**

If yes, place a check mark in each applicable box; specify other observations.

	Side to Side	Flexion	Extension	Other Observations
a. Head				
b.Trunk				No Difficulty

Appraisal Number
1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER ☐☐☐☐☐☐☐☐☐

B. Strength, Balance, and Coordination

Note—(1) If the client is bed-bound or chair-bound, complete only those test items that can be performed under those conditions; (2) observe balance and coordination (Item 7-8) while testing items 1-6; (3) perform tests and check as applicable; and (4) specify other observations.

1. Patient can dorsiflex foot, and with knee extended, raise leg 10 inches from bed, hold 5 seconds, lower to bed.
   Right Leg: ☒ Yes ☐ No Left Leg: ☐ Yes ☒ No
   Other Observations Has Frozen or Flail Joints
2. Patient can roll from supine to prone in each direction.
   Right to Left: ☒ Yes ☐ No Left to Right: ☒ Yes ☐ No
   Other Observations
3. Patient can sit up unassisted, swing legs over side of bed and return. ☒ Yes ☐ No
   Other Observations
4. Patient can grasp examiner's hand with normal strength hand grip.
   Right Hand: ☐ Yes ☒ No Left Hand: ☐ Yes ☒ No
   Other Observations Finger Joints Impaired
5. Patient can stand erect having used chair arms for support. ☒ Yes ☐ No
   Other Observations
6. Patient can stand erect unsupported, and with elbows extended, raise both arms above head, hold for 5 seconds.
   ☒ Yes ☐ No
   Other Observations
7. Patient appears to have normal balance when sitting unsupported and standing unsupported.
   Sitting: ☒ Yes ☐ No Standing: ☒ Yes ☐ No
   Other Observations
8. Patient appears to have normal coordination when moving body parts. ☐ Yes ☒ No
   Other Observations Difficulty in Walking

Review questions in Section A—Range of Motion and Section B—Strength, Balance, and Coordination. If any restrictions and/or impairments are observed, the patient should be seen by a physical or occupational therapist for a more thorough examination.

C. Activities of Daily Living

Indicate the level of performance by placing a check in every column that applies. Think of these functional abilities in relation to the individual's rehabilitation potential when answering parts of question 5 on page 3 of this instrument.

FUNCTION	A NO PROBLEM	B MECHANICAL AID	C HUMAN HELP	D # PERSONS HELPING	E DOES NOT PERFORM	F. REMARKS
1. MOBILITY						
a. Goes Outside		✓				Arthritis Pain or Motion
b. Walking		✓				" " "
c. Climbing Stairs					✓	
d. Transferring	✓					
e. Wheeling	✓					
2. PERSONAL CARE						
a. Bathes/Showers	✓					
b. Toileting	✓					
c. Dressing	✓					
d Grooming	✓					
e. Eating	✓					Snacks Between Meals

DENTAL/ORAL STATUS

Case AA-11

SAMPLE

See Instructions pp. 96-99

Appraisal Number

1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Use a tongue depressor or dental mirror and flashlight to make the examination. Check all boxes that apply and record other problems in space provided to describe condition of the mouth.

	None	1-10	11+	Satisfactory	Decay	Fracture	Pain	Loose	Unclean
Natural Teeth	✓								
Dentures Complete or Partial	None	Upper / Uses	Lower / Uses	Satisfactory	Broken	Missing Teeth	Uncomfortable	Loose	Unclean
		✓ / ✓	✓ / ✓						

Oral Soft Tissues	Normal	Gums Inflamed	Dry Mouth	Ulcer, Sore, Lump, or Other Lesion					
				Tongue	Under Tongue	Lips	Palate	Cheeks	Gums

Other Dental/Oral Problems: Dentures Are Not Uncomfortable or Painful

NUTRITIONAL STATUS

1. Is there a special diet prescribed?
   ☐ No ☒ Yes
   If yes, check appropriate diet(s) listed below.
   ☐ a. Mechanical Soft Diet
   ☐ b. Bland-Low Residue Diet
   ☒ c. Diabetic Diet
   ☒ d. Calorie Restricted Diet
   Specify calorie level: 1200
   ☐ e. Sodium Restricted Diet
   ☐ f. Fat Modified Diet
   ☐ g. Other, specify: _____
2. Is there an intake problem?
   ☐ No ☒ Yes
   If yes, check those that apply below.
   ☐ a. Solid Food Problem (Specify): Snacks Between Meals
   ☐ b. Fluid Intake Problem (Specify): _____
3. Is there an output problem?
   ☒ No ☐ Yes
   If yes, check those that apply below.
   ☐ a. Constipation
   ☐ b. Diarrhea
   ☐ c. Fluid Retention
   ☐ d. Other (Specify): _____
4. Are there food likes or dislikes?
   ☒ No ☐ Yes
   If yes, complete the folowing:
   a. Are they recorded? ☐ Yes ☐ No
   b. Are they carried out? ☐ Yes ☐ No
5. Are there cultural/religious constraints? ☒ No ☐ Yes
   If yes, complete the folowing:
   a. Are they recorded? ☐ Yes ☐ No
   b. Are they carried out? ☐ Yes ☐ No
6. Are supplementary nourishments given, e.g., a high protein commercial preparation ☒ No ☐ Yes
   If yes, specify _____
7. What is the usual dining location? Dining Room
8. Weight (this appraisal) 182 lbs.
9. Has there been a recent weight change? ☒ No ☐ Yes
   If yes, specify whether gain or loss and how much. _____

PSYCHOSOCIAL FACTORS

Case AA-12 SAMPLE

See Instructions pp. 99–103)

Appraisal Number

1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

PATIENT ID NUMBER [ ][ ][ ][ ][ ][ ][ ][ ]

A. Patient's Adjustment to Care Plan

Note: The following items may not be applicable to a newly admitted patient. If care plan has not been developed on first appraisal, omit this item and write N.A. in the margin. Complete on subsequent appraisals when care plan has been developed.

ITEM	PATIENT		FAMILY/SURROGATE	
	YES	NO	YES	NO
1. Involved in care planning		✓		
2. Cooperated actively—with positive attitude and enthusiasm		✓		
3. Cooperated passively—made no inputs, but carried out plan		✓		
4. Found fault with some items in the care plan but followed plan				
5. Found fault with items in the care plan and refused to cooperate				
6. Was provided with an educational experience explaining the rationale for the treatment and care plan	✓			

B. Patient's Social Interaction and Adjustments to the Facility

Describe the pattern of behavior for the individual by checking the appropriate column for each item.

ITEM	USUALLY	OCCASIONALLY	NEVER
1. Is oriented to the time and space of his/her living environment.	✓		
2. Cooperates with rules and regulations.	✓		
3. Asserts self and makes needs known.	✓		
4. Participates in self-directed activities.	✓		
5. Personalizes living space.	✓		
6. Personalizes apparel.	✓		
7. Participates in structured activity program.	✓		
8. Eats in dining room (if physically capable).	✓		
9. Spends free time outside his/her own room.	✓		
10. Has visitors from outside the facility.			✓
11. Visits others outside the facility.	✓		
12. Has outside contacts, i.e., letters, calls, etc..		✓	
13. Talks about events that go on outside the facility.	✓		
14. Engages in conversation with staff.	✓		
15. Engages in conversation with fellow patients.	✓		
16. Relates in an appropriate adult manner to fellow patients.	✓		
17. Relates in an appropriate adult manner to staff.	✓		

C. Behavioral Problems

Describe the usual manner of behavior for the individual by checking the appropriate column for each item (1-15). Indicate in Column A those behaviors which have not been exhibited; and in Column B those that have been exhibited by the patient and specify by checking the appropriate box which of those behaviors interfere with the functional capacity, require special care, and/or supervision.

BEHAVIORS	(A) DOES NOT EXHIBIT	(B) EXHIBITS	
		DOES NOT INTERFERE	INTERFERES
1. Apprehensive		✓	
2. Withdrawn	✓		
3. Hyperactive	✓		
4. Abusive to self	✓		
5. Disruptive	✓		
6. Hostile	✓		
7. Abusive to others	✓		
8. Wanders	✓		
9. Forgetful	✓		
10. Confused	✓		
11. Delusional	✓		
12. Hallucinates	✓		
13. Emotionally labile	✓		
14. Depressed		✓	
15. Inappropriate behavior, other specify _____			

If the individual's adjustment to the care plan, his/her social interaction and adjustment to the facility, or behavioral characteristics affect his/her functional capacity or necessitate additional care and/or supervision, then consideration should be given to having the patient examined by a psychiatrically oriented professional such as a psychiatric or other qualified social worker, psychiatric nurse, clinical psychologist or psychiatrist.

PATIENT CARE

See Instructions pp. 103-109

Appraisal Number

1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

A. Special Procedures

For each procedure listed below, check those given at the time of this appraisal, and indicate the frequency performed and by whom.

	PROCEDURE	FREQUENCY	BY WHOM
General Nursing Care	☐ 1. Preventive Skin Care		
	☐ 2. Decubitus Care		
	☐ 3. Sterile Protective Dressings		
	☐ 4. Turning Schedule or Repositioning		
	☐ 5. Oxygen Rx		
	☐ 6. Inhalation IPPB		
	☐ 7. Suctioning		
	☐ 8. Irrigation—Bladder		
	☐ 9. Irrigation—Other than Bladder		
	☐ 10. Ostomy Care		
	☐ 11. Enemas		
	☐ 12. Hydrotherapy (e.g., Whirlpool Baths, Soaks)	5x a week	PT
	☐ 13. Maintenance Ambulation	Daily	Nurses Aide
	☐ 14. Restraints		
	☐ 15. Other (Specify) FBS/Clinitest	1x a week / 3x a day	LAB / Nurses Aide
Rehabilitation/Restorative	☐ 16. Speech Pathology/Audiology		
	☐ 17. Bowel Training		
	☐ 18. Bladder Training		
	☒ 19. Passive Exercises Hand, Knees, Ankles	Daily	Nurses Aide
	☐ 20. Transfer Skills Training		
	☒ 21. Active Exercises " " "	Daily	Nurses Aide
	☐ 22. Resistive Weight Lifting Exercises		
	☐ 23. Gait Training		
	☐ 24. Prosthetic Training		
	☐ 25. Other (Specify)		
Teaching	☒ 26. Diet Instruction	X1	Dietician
	☐ 27. Ostomy Care (Type)		
	☐ 28. Foot Care		
	☐ 29. Self Injection		
	☒ 30. Other (Specify) Diabetes	1x a week	Nurse
Psychosocial	☒ 31. Self-directed Activities	Daily	Self
	☒ 32. Group Activities	1x a week	Activities Director
	☒ 33. Religious Activities	Daily	Self
	☐ 34. Reality Orientation Therapy		
	☒ 35. Remotivation Therapy	2x week	Social Worker
	☐ 36. Behavior Modification Therapy		
	☐ 37. Social Counseling		
	☐ 38. Other (Specify)		

B. Professional Visits

Was a professional visit by the attending physician or a consultant made to the patient/resident during this appraisal period.

☐ No ☒ Yes

If yes, indicate below the date(s) on which such visits were made.

	DATE(S)
☒ 1. Attending Physician (M.D. or D.O.)	October 2, 1977
☐ 2. Consultant Physician (M.D. or D.O.)	
☐ 3. Dentist	
☐ 4. Optometrist or Ophthalmologist	
☐ 5. Speech Pathologist/Audiologist	
☐ 6. Psychologist	
☐ 7. Podiatrist	
☐ 8. Other (Specify) _____	

C. Medications

In the following chart, identify by name, the medication in each category actually given on the day chosen for review. Record the unit dosage (e.g., 65 mg., ii tab., 10-units, etc.), the number of times the drug was given (e.g., 1, 3, 6, etc.), and the route of administration (e.g., p.o., (H), etc.). See Appendix B. Drug Classification Guide for explanation of categories.

CATEGORY	NAME	DOSAGE	# OF TIMES	ROUTE OF ADMIN.
1. Adrenal Cortical Hormones, etc.				
2. Analgesics	Daryon	65,32,32	3	p.o.
3. Antacids	Maalox	30cc	1	
4. Anticoagulants				
5. Anticonvulsants				
6. Antidepressants				
7. Antidiarrheals				
8. Antihistamines				
9. Antihypertensives				
10. Anti-infectives				
11. Anti-Parkinsonism Agents				
12. Bronchodilators				
13. Cardiac Drugs	Lanoxin	0.25mg	1	p.o.
	Quinidine Sulfate	i or ii tab.	2	p.o.
14. Cathartics	Dioctyl	i tab.	1	p.o.
15. Diuretics	Lasix	ii tab.	1	p.o.
16. Electrolyte/Fluid Replacements	KCL	10cc	3	p.o.
17. Estrogens/Androgens				
18. Expectorants/Cough Preparations				
19. EENT Preparations				
20. Insulin/Antidiabetic Agents	Insulin NPH U100	40 Units	1	H
21. Narcotic Analgesics				
22. Sedatives/Hypnotics				
23. Skin/Mucous Membranes	Valisone Cream		1	Locally
24. Spasmolytics/Antispasmodics				
25. Stimulants				
26. Thyroid Replacements				
27. Tranquilizers				
28. Vasodilating Agents				
29. Vitamins/Minerals				
30. Other				
31. Additional Drugs/Category: 2	Aspirin Buffered	ii tab.	1	p.o.
(Use Categories 1-29 above) 20	Insulin NPH U100	10 Units	1	H
13	Nitroglycerin	i tab.	1	Subling

Total # of Medications: 11
Total # Given by IM or IV or Subcutaneous route: 1
Total # Given that require additional supervision or care: _____
Date of Day Chosen for Appraisal Review 10 / 11 / 77
month day year

Since last appraisal, were there any manisfestations of undesired side effects or toxicity due to medications including allergic reaction, interactions, drug dependence, etc.

☒ No ☐ Yes

If yes, specify type, time of occurrence, and steps taken to alleviate the problem _____

When was the last time medications were reviewed? Date: ___ / ___ / ___
month day year

By whom were medications reviewed? (Check all that apply)

☐ Pharmacist ☐ Physician ☐ Nurse

☐ Other, specify _____

Case AA-15

SCHEDULE A
MEDICAL DATA

SAMPLE

Appraisal Number

1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

PATIENT ID NUMBER

[ ][ ][ ][ ][ ][ ][ ][ ]

1. Medically Defined Conditions

Indicate below any new or reactive medically defined conditions not identified at time of admission or first appraisal. Follow approved medical record keeping system of your institution and State, such as the use of ICDA-9-CM Classification Codes. Give date of onset of condition and include as appropriate in next care plan.

CLASS.	DIAGNOSIS	DATE OF ONSET	COMMENTS

2. Medical Status Measurements (Record new additional test findings after first appraisal).

TEST	DATE/READING 2	DATE/READING 3	DATE/READING	DATE/READING
Blood Sugar	Oct. 7 / 168 mg.%	Oct. 13 140 mg.%		
Hemoglobin	Oct. 7 / 11.6 Gm.			
Urine Albumin	Oct 7 / Neg.	Oct. 13 / Neg.		
Urine Sugar	Oct. 7 / Neg.	Oct. 13 / Neg.		
Urine Acetone	Oct. 7 / Neg.	Oct. 13 / Neg.		

The Patient Care Plan

October 17, 1977

Two weeks ago Alice Abrams entered the long-term care facility as a resident. Mrs. Abrams' health care team has met and from her appraisal data, extracts her problems and their priority of care. Each problem's goal, target date, and plan of care are decided and recorded on Care Planning Form #1*(p.AA-18)*. Each impairment, goal, and its target date are recorded on a Goal Achievement Summary Form *(AA20)*. Attending the care planning session are those persons directly involved with Mrs. Abrams' care, including the physical therapist, social worker, dietitian, nurse's aide, and PCM appraiser. Because Mrs. Abrams is physically and mentally alert, the PCM appraiser has recommended that she be present to participate in her own care planning. The first step in developing her care plan is to list major concerns that have been identified during the appraisal and recorded on the PCM instruments. When each major concern has been reviewed, the next step is to establish priorities. This is done by grouping related conditions and deciding their order of importance—which ones may affect Mrs. Abrams most and which ones need to be dealt with first. The care plan selected for Mrs. Abrams has one overall objective—to improve her functional status.

The date for the next care evaluation and planning session is scheduled for November 18, 1977.

Case AA-18

Patient's Name: Alice Abrams

Patient's ID Number: 000-00-0000

Date Care Planning Session: 10 (Month) 13 (Day) 77 (Year)

Session No.: 1

Date Appraisal Completed: 10 (Month) 14 (Day) 77 (Year)

Team Present: RN, PT, Diet., SW., Aide

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM
Dx: Arthritis 1) Pain hands and legs 2) Reduced ROM a) hands b) ankles c) knees	1) Reduce pain as indicated by reduction of pain Rx from 4x to 2x/day 2) Increase ROM to permit a) hands: letter writing, self injection of Insulin b) knees and ankles: ambulation to dining room, activities w/o discomfort	11/15	1) & 2) whirlpool - 1 hr. treatment hands and legs Hot packs - 1 hr. Treatment hands and knees 2) Hand exercises with ball 3) Maintenance ambulation	3x/week 2x/week Daily Daily	PT PT Aide RN, Aide
Dx: Diabetes 3) FBS - 198 mg% 4) Intake problem	3) Reduce FBS to 120 mg% 4) Increased understanding of diabetes and diet necessary to keep on diet	11/15 11/15	3) Obtain blood specimen for FBS Give 10 U NPH insulin (100 u/at 7 p.m. daily (as per M.D.'s order) Test urine before meals 4) Patient education - Diabetes Dietary counseling Prevent snacking	1x Week Daily 3x/day 1x/week 1x/week Cont.	RN Aide RN Dietician All Staff
Dx: ASHD 5) Angina	5) Prevent occurrence	Ongoing	5) Maintain regimen by Lasix, Lanoxin	Daily	LPN
Vision Impairment 6) Can't see numbers on insulin syringe	6) Determine possibility of compensating for poor vision	11/15	6) Check glasses to see if better correction is possible	1x	Opth.
Psychological Status 7) Apprehension 8) Antagonistic 9) Depression	7, 8) Decrease apprehension, antagonism, 9) and depression by facilitating adjustment to facility	11/15	7, 8) Verbalization of positive and 9) negative feelings through daily contacts Remotivation therapy	Daily 2x/week	RN, Aides, Activities Director Social Worker

Date Next Care Planning Session: 11 (Month) 18 (Day) 1977 (Year)

Patient's Name _____ Date Care Planning Session ____/____/____ Session No. _____
Month Day Year

Patient's ID Number | | | | | | | | | | | Date Appraisal Completed ____/____/____ Team Present _____
Month Day Year

CARE PLANNING

Case AA-17

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM

Date Next Care Planning Session ____/____/____
Month Day Year

Case AA-20

Patient's Name Alice Abrams Patient's ID Number 000-00-0000 Summary No. 1

Date Care Planning Session 10/14/77

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		
1.	Reduce Pain Rx from 4x to 2x day	11/15	11/17		X		X			Still receiving Darvon full Strength 3x/day.
2.	Increase ROM hands, knees, and ankles	11/15	11/15		X		X			Writes a few letters each week walks to dining room with less pain and discomfort
3.	FBS 120 mg. %	11/15	11/13		X		X			FBS 168 mg. %
4.	Keep on dialectic diet	11/15	11/15		X		X			Still snacking
5.	Minimize stress to prevent angina occurrence	On going	11/15	X			X		On going	No Angina
6.	Compensate for poor vision	11/15	11/17	X			X			Ophthalmologist saw patient 11/7/77. Glasses OK. No further correction possible
7.	Decrease apprehension	11/15	11/15		X		X			
8.	antagonism, and depression									Showing some improvement. No longer antagonistic.
9.	by facilitating adjustment to facility									

Patient's Name _____ Patient's ID Number _____ Summary No. _____

Date Care Planning Session _____

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		

November 15, 1977

Mrs. Abrams' reappraisal (Appraisal II) is begun.

November 18, 1977

Mrs. Abrams' reappraisal is completed (Appraisal II).

The reappraisal (Appraisal II) data are found on the following pages (AA-22-23).

PATIENT CARE

SAMPLE
See Instructions pp. 103–107

Appraisal Number

1	2	3	4	5	6
☐	☒	☐	☐	☐	☐

A. Special Procedures
For each procedure listed below, check those given at the time of this appraisal, and indicate the frequency performed and by whom.

	PROCEDURE	FREQUENCY	BY WHOM
General Nursing Care	☐ 1. Preventive Skin Care		
	☐ 2. Decubitus Care		
	☐ 3. Sterile Protective Dressings		
	☐ 4. Turning Schedule or Repositioning		
	☐ 5. Oxygen Rx		
	☐ 6. Inhalation IPPB		
	☐ 7. Suctioning		
	☐ 8. Irrigation—Bladder		
	☐ 9. Irrigation—Other than Bladder		
	☐ 10. Ostomy Care		
	☐ 11. Enemas		
	☒ 12. Hydrotherapy (e.g., Whirlpool Baths, Soaks)	5 x a week	PT
	☒ 13. Maintenance Ambulation	Daily	Nurses Aide
	☐ 14. Restraints		
	☒ 15. Other (Specify) FBS/Clinitest	1 x a week / 3 x a day	LAB / Nurses Aide
Rehabilitation/Restorative	☐ 16. Speech Pathology/Audiology		
	☐ 17. Bowel Training		
	☐ 18. Bladder Training		
	☒ 19. Passive Exercises Hand, Knees, Ankles	Daily	Nurses Aide
	☐ 20. Transfer Skills Training		
	☒ 21. Active Exercises " " "	Daily	Nurses Aide
	☐ 22. Resistive Weight Lifting Exercises		
	☐ 23. Gait Training		
	☐ 24. Prosthetic Training		
	☐ 25. Other (Specify)		
Teaching	☒ 26. Diet Instruction	X /	Dietician
	☐ 27. Ostomy Care (Type)		
	☐ 28. Foot Care		
	☐ 29. Self Injection		
	☒ 30. Other (Specify) Diabetes	1 x a week	Nurse
Psychosocial	☒ 31. Self-directed Activities	Daily	Self
	☒ 32. Group Activities	1 x a week	Activities Director
	☒ 33. Religious Activities	Daily	Self
	☐ 34. Reality Orientation Therapy		
	☒ 35. Remotivation Therapy	2 x week	Social Worker
	☐ 36. Behavior Modification Therapy		
	☐ 37. Social Counseling		
	☐ 38. Other (Specify)		

PATIENT CARE (Cont'd)

(See Instructions pp. 107-108)

B. Professional Visits –

Was a professional visit by the attending physician or a consultant made to the patient/resident during this appraisal period.

☐ No ☐ Yes

If yes, indicate below the date(s) on which such visits were made.

	DATE(S)
☐ 1. Attending Physician (M.D. or D.O.)	
☐ 2. Consultant Physician (M.D. or D.O.)	
☐ 3. Dentist	
☐ 4. Optometrist or Ophthalmologist	
☐ 5. Speech Pathologist/Audiologist	
☐ 6. Psychologist	
☐ 7. Podiatrist	
☐ 8. Other (Specify) _____	

PATIENT CARE (Cont'd)

C. Medications (See Instructions pp. 108-109)

In the following chart, identify by name, the medication in each category actually given on the day chosen for review. Record the unit dosage (e.g., 65 mg., ii tab., 10 units, etc.), the number of times the drug was given (e.g., 1, 3, 6, etc.), and the route of administration (e.g., p.o., (H), etc.). See Appendix B. Drug Classification Guide for explanation of categories.

CATEGORY	NAME	DOSAGE	# OF TIMES	ROUTE OF ADMIN.
1. Adrenal Cortical Hormones, etc.				
2. Analgesics	Darvon	65, 32, 32 mg	3	p.o.
3. Antacids (p.r.n. @ bedside)	Maalox	30cc	1	p.o.
4. Anticoagulants				
5. Anticonvulsants				
6. Antidepressants				
7. Antidiarrheals				
8. Antihistamines				
9. Antihypertensives				
10. Anti-infectives				
11. Anti-Parkinsonism Agents				
12. Bronchodilators				
13. Cardiac Drugs	Lanoxin	0.25 mg	1	p.o.
	Quinidine sulfate	i tab or ii	2	p.o.
14. Cathartics	Dioctyl	i tab	1	p.o.
15. Diuretics	Lasix	ii tab	1	p.o.
16. Electrolyte/Fluid Replacements	KCL	10cc	3	p.o.
17. Estrogens/Androgens				
18. Expectorants/Cough Preparations				
19. EENT Preparations				
20. Insulin/Antidiabetic Agents	Insulin NPH U100	40 units	1	H
21. Narcotic Analgesics				
22. Sedatives/Hypnotics				
23. Skin/Mucous Membranes	Valisone Cream		1	Locally
24. Spasmolytics/Antispasmodics				
25. Stimulants				
26. Thyroid Replacements				
27. Tranquilizers				
28. Vasodilating Agents				
29. Vitamins/Minerals				
30. Other				
31. Additional Drugs/Category: 2	Aspirin Buffered	ii tab	1	p.o.
(Use Categories 1-29 above) 20	Insulin NPH U100	10 units	1	H
13	Nitroglycerine	i tab	1	Subling

Total # of Medications: 11
Total # Given by IM or IV or Subcutaneous route: 1
Total # Given that require additional supervision or care: _____
Date of Day Chosen for Appraisal Review 11 / 15 / 77
month day year

Since last appraisal, were there any manifestations of undesired side effects or toxicity due to medications including allergic reaction, interactions, drug dependence, etc.
☐ No ☒ Yes
If yes, specify type, time of occurrence, and steps taken to alleviate the problem _____

When was the last time medications were reviewed? Date: ____ / ____ / ____
month day year

By whom were medications reviewed? (Check all that apply)
☐ Pharmacist ☐ Physician ☐ Nurse
☐ Other, specify _____

November 18 (Care Planning Session #2)

Mrs. Abrams' health care team meets.

Reappraisal data signify to the team that some of her old problems have been resolved since the date of her first care planning session. The date of this care planning session is entered opposite each problem resolved.

Using the patient's reappraisal data (AA 22-23) and Goal Achievement Summary #1 (p. 20), the team discusses each goal set on October 14, 1977. The appraiser records the reappraisal date, the goal achievement status, the services provided, and any pertinent comments from the team's collective evaluation.

The current priority of the patient's problems indicate that no changes have occurred, so the team continues to follow established goals and target dates and the plan of care for each. Care Planning Form #2 (AA 26) documents and summarizes their actions. (Compare each problem as found on Care Planning Form #1 (AA 19) and Care Planning Form #2 (AA 26).

Once Mrs. Abrams' new care plan is established, the goals and their target dates are recorded on Goal Achievement Summary Form #2 (p. AA-27).

The date for the next care evaluation and planning session is set for January 7, 1978.

Patient's Name Alice Abrams

Patient's ID Number 000-00-0000

Date Care Planning Session 11 / 15 / 77 (Month / Day / Year)

Session No. 2

Date Appraisal Completed 11 / 18 / 77 (Month / Day / Year)

Team Present R.N., P.T., Diet, SW Aide, Activities Dir.

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM
Dx: Arthritis 1) Pain	1) Reduce pain as indicated by reduction in use of pain Rx from 3x to 2x day	1/18/78	See Care plan of 10/14/77		
2) Reduced ROM	2) Same goal as care plan 10/14/77	1/18/77	See Care plan of 10/14/77		
Dx: Diabetes 3) FBS - 168 mg%	Same goal as care plan 10/14/77	1/18/77	See Care plan of 10/14/77		
4) intake problem	Same goal as Care plan 10/14/77	1/18/77	See Care plan of 10/14/77 and increase individual and group diversional activities (see problem #7 below)		
Dx: ASHD 5) Angina	same	ongoing	same		
Vision impairment 6) Can't see numbers on insulin syringe	same	12/2/77	Test vision on large numbered syringes	1x	RN
Psychosocial 7) apprehension, etc. 9) depression	Same	1/18/77	Same, Establish daily individual and group diversional activities plan	daily	Activities Director

Date Next Care Planning Session 1 / 20 / 78 (Month / Day / Year)

Patient's Name Alice Abrams Patient's ID Number 000-00-0000 Summary No. 2

Date Care Planning Session 11/18/78

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		
1	Reduce pain - Rx from 3x to 2x/day	1/18/78	1/19/78			X	X			Goal achieved, Now taking Darvon - 65mg., 32mg, 32mg (1/2 dose Darvon 2x = 1 dose)
2.	Increase ROM, Hands, Knees and Ankles	1/18/78	1/19/78			X	X			Writes to nephew, plays cards, Walks to D.R., activities and room w/o difficulty
3.	FBS - 120 mg. %	1/18/78	1/11/78		X		X			FBS = 140 mg. %
4.	Keep on diet	1/18/78	1/19/78		X		X			Snacking less. Has greater understanding of diabetes and diet, Continue plan
5	Minimize stress to prevent Angina occuring	ongoing	1/19/78				X			Patient had anginal attack on 12/22/77. All services suspended until 12/29/77. M.D. called, visited 12/22. No further pain
6.	Compensate for poor Vision	12/2/77	12/2/77			X	X			Can see numbers. Cannot hold syringe. Abandon plan for self injection.
7 8	Facilitate adjustment to facility, etc.	1/18/78	1/19/78			X	X			Seems well adjusted to surroundings. Participates well in social activities. Not apprehensive, but depressed @ times.

January 14, 1978

Mrs. Abrams' reappraisal (Appraisal III) is begun.

January 15, 1978

Mrs. Abrams' reappraisal (Appraisal III) is completed.

The reappraisal data are found on the following pages (p. AA-29-30).

PATIENT CARE

SAMPLE

See Instructions pp. 103-107

Appraisal Number

1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐

A. Special Procedures

For each procedure listed below, check those given at the time of this appraisal, and indicate the frequency performed and by whom.

	PROCEDURE	FREQUENCY	BY WHOM
General Nursing Care	☐ 1. Preventive Skin Care		
	☐ 2. Decubitus Care		
	☐ 3. Sterile Protective Dressings		
	☐ 4. Turning Schedule or Repositioning		
	☐ 5. Oxygen Rx		
	☐ 6. Inhalation IPPB		
	☐ 7. Suctioning		
	☐ 8. Irrigation—Bladder		
	☐ 9. Irrigation—Other than Bladder		
	☐ 10. Ostomy Care		
	☐ 11. Enemas		
	☒ 12. Hydrotherapy (e.g., Whirlpool Baths, Soaks) *	5 x a week	PT
	☒ 13. Maintenance Ambulation *	Daily	Nurses Aide
	☐ 14. Restraints		
	☒ 15. Other (Specify) FBS	1x a week 3x a day	Nurses Aide
Rehabilitation/Restorative	☐ 16. Speech Pathology/Audiology		
	☐ 17. Bowel Training		
	☐ 18. Bladder Training		
	☐ 19. Passive Exercises		
	☐ 20. Transfer Skills Training		
	☒ 21. Active Exercises Hand Exercise	DAILY	Nurses Aide
	☐ 22. Resistive Weight Lifting Exercises		
	☐ 23. Gait Training		
	☐ 24. Prosthetic Training		
	☐ 25. Other (Specify)		
Teaching	☒ 26. Diet Instruction	1 x a week	Dietitian
	☐ 27. Ostomy Care (Type)		
	☐ 28. Foot Care		
	☒ 29. Self Injection	1 x a week	Nurse
	☒ 30. Other (Specify) Diabetes	1 x a week	RN
Psychosocial	☒ 31. Self-directed Activities	DAILY	Aide
	☐ 32. Group Activities *	3 x a week	Activities Director
	☐ 33. Religious Activities	DAILY	Self
	☐ 34. Reality Orientation Therapy		
	☒ 35. Remotivation Therapy	2 x a week	Social Worker
	☐ 36. Behavior Modification Therapy		
	☐ 37. Social Counseling		
	☐ 38. Other (Specify)		

* THESE ACTIVITIES SUSPENDED FOR 1 WEEK because of Angina attack - Dec 10-22-29

PATIENT CARE (Cont'd)

SAMPLE

B. Professional Visits

Was a professional visit by the attending physician or a consultant made to the patient/resident during this appraisal period

☐ No ☒ Yes

If yes, indicate below the date(s) on which such visits were made

		DATE(S)
☒	1. Attending Physician (M.D. or D.O.)	12/12 and 12/22
☐	2. Consultant Physician (M.D. or D.O.)	
☐	3. Dentist	
☐	4. Optometrist or Ophthalmologist	
☐	5. Speech Pathologist/Audiologist	
☐	6. Psychologist	
☐	7. Podiatrist	
☐	8. Other (Specify) _____	

C. Medications

In the following chart, identify by name, the medication in each category actually given on the day chosen for review. Record the unit dosage (e.g., 65 mg., ii tab., 10 units, etc.), the number of times the drug was given (e.g., 1, 3, 6, etc.), and the route of administration (e.g., p.o., (H), etc.). See Appendix B. Drug Classification Guide for explanation of categories.

CATEGORY	NAME	DOSAGE	# OF TIMES	ROUTE OF ADMIN.
1. Adrenal Cortical Hormones, etc.				
2. Analgesics	DARVON	32mg	2	p.o.
3. Antacids				
4. Anticoagulants				
5. Anticonvulsants				
6. Antidepressants				
7. Antidiarrheals				
8. Antihistamines				
9. Antihypertensives				
10. Anti-infectives				
11. Anti-Parkinsonism Agents				
12. Bronchodilators				
13. Cardiac Drugs	LANOXIN	0.25 mg	1	p.o.
	Quinidine Sulfate	½ tab	2	p.o.
14. Cathartics	DIOCTYL	½ tab	1	p.o.
15. Diuretics	LASIX	½ tab	1	p.o.
16. Electrolyte/Fluid Replacements	KCL	10 cc	3	p.o.
17. Estrogens/Androgens				
18. Expectorants/Cough Preparations				
19. EENT Preparations				
20. Insulin/Antidiabetic Agents	INSULIN NPH U100	40 UNITS	1	H
21. Narcotic Analgesics				
22. Sedatives/Hypnotics				
23. Skin/Mucous Membranes	VALISONE CREAM		1	Locally
24. Spasmolytics/Antispasmodics				
25. Stimulants				
26. Thyroid Replacements				
27. Tranquilizers				
28. Vasodilating Agents				
29. Vitamins/Minerals				
30. Other				
31. Additional Drugs/Category: 20	INSULIN NPH U100	10 UNITS	1	H
(Use Categories 1-29 above)				

Total # of Medications: 8
Total # Given by IM or IV or Subcutaneous route: 1
Total # Given that require additional supervision or care: _____
Date of Day Chosen for Appraisal Review 1 / 14 / 78
month day year

Since last appraisal, were there any manisfestations of undesired side effects or toxicity due to medications including allergic reaction, interactions, drug dependence, etc.

☐ **No** ☐ **Yes**

If yes, specify type, time of occurrence, and steps taken to alleviate the problem _____

When was the last time medications were reviewed? Date: ____ / ____ / ____
month day year

By whom were medications reviewed? (Check all that apply)

☐ **Pharmacist** ☐ **Physician** ☐ **Nurse**

☐ **Other, specify** _____

January 15, 1978, Care Planning Session #3

Mrs. Abrams' health care team meets again.

PCM is a continuing process that consists of three sequential stages: patient appraisal, care planning and care evaluation. These stages are repeated at regular intervals for the duration of a patient's stay. In Mrs. Abrams' case, 30 days separated the first and second appraisals and 60 days the second and third.

The patient's reappraisal data indicate that several changes have been necessitated as a result of a mild heart attack. Other data indicate that some of her old problems have been resolbed.

Using the Goal Achievement Summary Form #2 (AA 27) and the patient's reappraisal data (AA 29-30), the team discusses each problem, the goal set to resolve the problem and the care that the patient has received to resolve the problem. The appraiser records the reappraisal date, the status of Goal Achievement and any pertinent comments.

The health care team decides that although the priority of the patient's problems has changed, the care she is receiving appears to be improving her functioning capacities. Care Planning Session #3 (AA 32) records that this team has chosen to have the patient continue with the priorities, goals, and plan of care established in Care Planning Session #3 with only minor exceptions. Goal Achievement Summary #3, (AA33), is a practice worksheet that will provide the student appraiser with an opportunity to complete this phase of the care plan. The inputs on this form should be based on all of the data that have been collected and analyzed up until this time.

Patient's Name Alice Abrams Date Care Planning Session 1 / 19 / 78 (Month / Day / Year) Session No. 3

Patient's ID Number 000-00-0000 Date Appraisal Completed 1 / 20 / 78 (Month / Day / Year) Team Present RN, PT, Aide

CARE PLANNING

Case AA-32

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM
Dx: Arthritis 1) Pain	Reduce pain further as indicated by reduction in use of pain RX from 2x day (32 mg) to 1x day @ h.s.	6/21/78	Continue care plan of 10/14/77		
2) ROM	Maintain present status (See Achievement summary 1/19)	6/21/78	Continue w/care plan of 10/14/77. Reappraise ROM 6/19/78		
Dx: Diabetes 3) FBS 140 mg.	Same goal as care plan 10/14/77	6/21/78	Continue w/care plan of 10/14/77		
4) Intake problem	Same goal as care plans 10/14/77 and 11/18	6/21/78	Continue w/ care plan of 11/18/77		
Dx: ASHD 5) Angina	Same goal as 10/14	6/21/78	Continue w/care plan of 10/14/77		
Psychosocial 9) Depression	Maintain present status (See achievement summary 1/19)	6/21/78	Continue w/ care plan of 10/14 and 11/18/77		

Date Next Care Planning Session 6 / 23 / 78 (Month / Day / Year)

Patient's Name _____ Patient's ID Number _____ Summary No. _____

Date Care Planning Session _____

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAI-SAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		

APPENDIX D
Sample Case #2 Catherine Crenski

APPENDIX D

Sample Case #2—Catherine Crenski

To help you further understand the pattern of activities involved in the PCM process, the records of a second case are included in this manual. The PACE records of Catherine Crenski (C.C.), a skilled nursing facility patient, document her progress as she is admitted after a traumatic incident for rehabilitation in order to return to independent living. The records are sequential so that the continuum of appraisal, care planning, care evaluation and reappraisal may be seen. Prior to reviewing Mrs. Crenski's forms, you may wish to reread sections on Care Planning and Evaluation.

Sept. 1, 1977

Mrs. Catherine Crenski is admitted to the long-term care (LTC) facility.

Sept. 2, 1977

Mrs. Crenski's initial PACE Appraisal I is begun.

Sept. 8, 1977

Mrs. Crenski's Appraisal I is completed.

The Appraisal I data are found on the following pages (CC1-17).

(Extract of LTC Facility Admission Records)

Catherine Crenski

- age 76
- Height 5'2"
- weight present 120 lbs.
  (usual—135 lbs.)
- Marital status—widowed—1 child (57 years old)
- living arrangements—lives alone in family home which she has occupied for 24 years; daughter and her family live in nearby town (mid-western state)
- racial/ethnic background
- Caucasian
- Russian
- usual occupation—homemaker
- church volunteer work

Background—Mrs. Crenski has lived alone since death of husband three years ago. They enjoyed his retirement together for 10 years and modest income from savings, social security, and retirement benefits. She is covered by Blue-Cross-Blue-Shield and Medicare; her home is completely paid for.

Presenting problems—Mrs. Crenski is admitted to the Long-Term Care facility September 1, 1977 from a community hospital, 3 weeks post-surgery for pinning of fracture of neck of femur (L).

PACE II INSTRUMENT

Sample

ADMISSION DATA

See Instructions pp. 43-47

1. Provider Identification 000-000
2. Patient Identification Number 000-00-0000 CC
3. Provider Location
4. Provider Type (Specify type) SNF
   (See Supplementary Classification of Providers in Appendix A)
5. Date of Latest Admission to Provider 9 / 1 / 1977
   month day year
6. Date of First Admission to Provider / / none
   month day year
7. Date of Latest Discharge from Provider / /
   month day year
8. Number of Prior Admission(s) to Provider none
9. Last Principal Provider (Specify type) GENERAL HOSPITAL
   (See Supplementary Classification of Providers)
10. Physician's Prognosis on Admission
    Indicate below the attending physician's prognosis at the time of admission for the client:

☐ **No Change** ☐ **Improvement** ☐ **Deterioration** ☐ **Not Determined** ☒ **Has Discharge Potential (Use Schedule C)**

DEMOGRAPHIC DATA

1. Date of Birth 01 / 19 / 01
   month day year
2. Sex: ☐ **Male** ☒ **Female**
3. Race/Ethnicity
   a. Race.
      ☐ **American Indian or Alaskan Native** ☐ **Asian or Pacific Islander** ☐ **Black**
      ☒ **White** ☐ **Not Determined**
   b. Ethnicity
      ☐ **Hispanic Origin** ☒ **Not of Hispanic Origin** ☐ **Not Determined**
4. Current Marital Status
   ☐ **Never Married** ☐ **Married** ☒ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Not Determined**
5. Usual Residence *(Type of residence in which the patient has been residing for the past six months. For clients continuously in an institutional setting for six months or more, the facility will be considered his/her residence.)*
   ☒ **Home/Apartment** ☐ **Rented Room, Commercial Hotel** ☐ **Supportive Housing** ☐ **Institutional Setting**
6. Residence/Location
7. Usual Living Arrangement *(Check all that identify with whom the patient has been living during the past six months.)*
   ☒ **Lived Alone** ☐ **Lived with Spouse** ☐ **Lived with Family** ☐ **Lived with Others**
8. Court Ordered Constraints
   a. Is the client under court ordered care? ☒ **No** ☐ **Yes**
   b. Does he/she have a court appointed guardian? ☒ **No** ☐ **Yes**

DISCHARGE DATA

(To be filled out only at the time of discharge from latest admission to provider.)

1. Discharge Date / /
   month day year
2. Status on Discharge (Check most applicable)
   ☐ **Improved** ☐ **No Change** ☐ **Deteriorated** ☐ **Deceased**
3. Discharged to: (Specify type)
   (See Supplementary Classification of Providers)

MEDICAL DATA

SAMPLE

(Instructions on pp. 47-52)

Appraisal Number

1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

A. Medically Defined Conditions

At the time of admission or first appraisal, record all medical conditions for which the client is actually receiving care by indicating with a check mark the single primary diagnosis and all secondary diagnoses as applicable. Write in the specific diagnoses in the last column. (Instructions on pp. 47-51)

DIAGNOSTIC CATEGORY	PRIM.	SEC.	SPECIFIC DIAGNOSES
Neoplasms			
Endocrine, Nutritional, Metabolic Diseases, and Immunity Disorders			
Diseases of Blood and Blood-forming Organs		X	Mild Nutritional Anemia
Organic Psychotic Conditions			
Other Psychoses			
Neurotic and Personality Disorders			
Mental Retardation, mild			
Mental Retardation, moderate			
Mental Retardation, severe			
Mental Retardation, unspecified level			
Diseases of the Nervous System and Sense Organs			
Stroke, including late effects			
Atherosclerosis			
Diseases of the Circulatory System other than Stroke and Atherosclerosis		X	Mild Angina Pectoris
Diseases of the Respiratory System			
Diseases of the Digestive System			
Diseases of the Genitourinary System			
Diseases of the Skin and Subcutaneous Tissue			
Diseases of the Musculoskeletal System and Connective Tissue		X	Osteoarthritis in Hands
Congenital Anomalies			
Injury and Poisoning	X		Fx neck of (L) Femur- Surgically pinned
Symptoms, Signs, and Ill-defined Conditions			
Other diagnosis			
Unknown diagnosis			
No disease			

Schedule A should be used for subsequent appraisals if (1) a previously unrecognized condition is diagnosed and requires care, or (2) a previously recognized condition, that did not require care formerly, becomes active.

B. Medical Status Measurements

On the initial appraisal, record the results of the latest measurements and indicate the date on which the test was made. Any tests done or repeated at a later date should be recorded on Schedule A.

TEST		DATE
1. Height	5'2" (inches)	9/1/77
2. Weight	120 (pounds) Usual wt. 136 lbs	9/1/77
3. Blood Pressure	130 / 90 (Systolic) (Diastolic)	9/1/77
4. Pulse Rate	82(L) 84(R) (per minute) (Radial)	9/1/77
5. Respiratory Rate	16 (per minute)	9/1/77
6. Blood Tests (Type of Test: [X] Fasting [ ] Postprandial for Blood Sugar below)		
a. Blood Sugar	96 (mg. %)	8/26/77
b. Blood Urea Nitrogen	10 (mg. %)	8/26/77
c. Hemoglobin	12 (Gm.)	8/26/77
d. Hematocrit	36 (%)	8/26/77
7. Urine Tests (record as negative, trace, or one or more +'s)		
a. Albumin (Type ____)	Neg	
b. Sugar (Type ____)	Neg	
c. Acetone (Type ____)	Neg	
8. Stool Test for Occult Blood (Type ____) (Record as negative, trace, or one or more +'s)	Neg	
9. Other, specify ____		

Case CC-7
Appraisal I

PATIENT APPRAISAL DATA

SAMPLE
See Instructions pp. 53-54

Appraisal Number
1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

PATIENT ID NUMBER
[0][0][0][0][0][0][0][0][0]

PACE APPRAISER: Jane Doe, RN
Name and Discipline

Beginning Date of Appraisal 9/2/77

Type of Appraisal [X] Admission/Initial [ ] Periodic
[ ] Routine (Annual) [ ] Discharge
[ ] Other (Specify) _____

1. Present Level of Care (Check appropriate box)
   [X] Skilled Nursing Care
   [ ] Intermediate Care
   [ ] Other (Specify) _____
2. Present Reimbursement Source(s). Indicate in the space provided whether (P) principal or (S) supplemental; (unless a change has occurred since last appraisal, omit this question).
   P Medicare (Title XVIII) — S All Other Public Sources
   _____ Medicaid (Title XIX) — S Blue Cross or Commercial Health Insurance
   _____ Social Services (Title XX) — _____ Self Pay
   _____ V.A. — _____ No Charge
   _____ Workers' Compensation — _____ Not Determined
3. Have any incidents or accidents occurred involving this patient since the last appraisal?
   [ ] No [ ] Yes
   If yes, give details N/A - first appraisal
4. Has there been a significant change in the individual's physical or emotional status since the last appraisal?
   [ ] No [ ] Yes
   If yes, give details N/A - first appraisal
5. Rehabilitation Potential:
   a. Is there a possibility of restoring the indivdual from his/her present physical and/or emotional functional level to a higher level of function? (check appropriate box)
      [ ] No [X] Yes
   b. If yes, explain in what functional areas this is possible achieve ambulation
   c. If no, is there a possibility of preventing deterioration of the present physical and/or emotional state to sustain the individual's current capacities? (check appropriate box)
      [ ] No [ ] Yes
   d. If yes, specify the functional areas _____
   e. If no, is there a possibility of slowing down the process of deterioration? (check appropriate box)
      [ ] No [ ] Yes
   f. If yes, specify the functional areas _____
6. If improving, is discharge anticipated within one month?
   [X] No [ ] Yes
   If yes, complete Schedule C.

Fill in this section at end of appraisal.
Check appropriate box(es) indicating the professional discipline of persons contributing to this appraisal:

[X] R.N. — [ ] Social Worker
[ ] L.P.N. — [X] Physical Therapist
[X] Aide/Orderly — [ ] Occupational Therapist
[ ] Other, specify _____

PACE Appraiser's signature Jane Doe, RN

Date of Completion of Appraisal: 9 / 8 / 77
month day year

Case CC-9
Appraisal I

IMPAIRMENTS

SAMPLE
See Instructions pp. 54-58

Appraisal Number
1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER
0 0 0 0 0 0 0 0 0

A. Skin
1. Are there any decubitus ulcers present at this appraisal: ☒ No ☐ Yes
If yes, indicate number of sites _____
2. Are there any other skin abnormalities: ☐ No ☒ Yes
If Item 1 and/or 2 is answered yes, complete Schedule B.

B. Extremities and Trunk
Are there any missing limbs or fracture/dislocation of the hip or other bone: ☐ No ☒ Yes
If yes, complete the following chart.

EXTREMITY		MISSING LIMBS Date of amputation, and Type: (BE) Below Elbow (AK) Above Knee (AE) Above Elbow (P) Prosthesis (BK) Below Knee	FRACTURED HIP(S) Date of Repair (R) or Prosthesis	OTHER FRACTURES/ DISLOCATIONS Date and Location
UPPER	R	NONE		
	L	↓		
LOWER	R			
	L		simple fx ⓛ femur neck - 8/11/77	

C. Sensory/Communication Status (check appropriate box(es)).
1. Vision (with glasses if customarily used)
☒ a. Normal or minimum loss ☐ c. Severe loss ☐ e. Not determined
☐ b. Moderate loss ☐ d. Total blindness
2. Hearing (with hearing aid if customarily used)
☒ a. Normal or minimum loss ☐ c. Severe loss ☐ e. Not determined
☐ b. Moderate loss ☐ d. Total deafness
3. Expressive Communication
Select the one category that best describes the **usual** method used by the patient in conveying information.
☒ a. Speaks and is usually understood ☐ d. Uses gestures, grunts, or primitive symbols
☐ b. Speaks but is understood only with difficulty ☐ e. Does not convey needs
☐ c. Uses structured sign language, symbol board, or writes ☐ f. Not determined
4. Receptive Communication
Select the one category that best describes the patient's **usual** method of understanding information conveyed by others.
☒ a. Hears and usually understands ☐ e. Does not understand
☐ b. Hears and understands only with difficulty ☐ f. Not determined
☐ c. Depends on lip reading, written materials, or structured sign language
☐ d. Understands only primitive gestures, facial expressions or simple pictograms and/or recognizes environmental cues

D. Bowel/Bladder Status
1. Is there bowel incontinence:
☒ No ☐ Yes
If yes, specify frequency of incidents _____
2. Are there any other bowel problems such as ostomy:
☒ No ☐ Yes
If yes, specify _____
If yes, is assistance needed? ☐ No ☐ Yes
3. Is there bladder incontinence:
☒ No ☐ Yes
If yes, specify frequency of incidents _____
4. Are there any other bladder problems such as ostomy, indwelling catheter or external device:
☒ No ☐ Yes
If yes, specify _____
If yes, is assistance needed? ☐ No ☐ Yes

PHYSICAL FUNCTION

SAMPLE
See Instructions pp. 58--96

Appraisal Number

1	2	3	4	5	6
☒	☐	☐	☐	☐	☐

Note—During any of the specified tests in Section A—Range of Motion and Section B—Strength, Balance, and Coordination, if the client indicates pain on motion, stop that portion of the test immediately. Proceed to another test. If tests in these sections are medically contraindicated, give reasons:

_____ **Date** ___/___/___

_____ **Date** ___/___/___

A. Range of Motion

With patient lying on back on bed, test passive movements of upper and lower extremities for full range of motion. Indicate by check in the chart below if there is restriction and/or disabling condition in any extremity. Specify other observations in the space provided.

RESTRICTED

PARTS OF THE BODY	FLEXION A	EXTENSION B	ABDUCTION C	ADDUCTION D	ROTATION E	OTHER OBSERVATIONS F.
1. Right Extremities						
a. Fingers/Thumb	✓	✓				Osteoarthritis in hands
b. Wrist	✓	✓				" " "
c. Elbow						
d. Shoulder						
e. Ankle						
f. Knee						
g. Hip						
2. Left Extremities						
a. Fingers/Thumb	✓	✓				" " "
b. Wrist	✓	✓				" " "
c. Elbow						
d. Shoulder						
e. Ankle						
f. Knee	✓	✓				F ✓ ⓛ neck of femur - surgically pinned
g. Hip	✓	✓	✓	✓	✓	

3. Head and Trunk

With patient sitting unsupported on side of bed, test range of motion of head and trunk. If patient cannot sit unsupported on side of bed for any reason, indicate in the margin that the test was not done. If appropriate, complete test at a later date.

Is there any restriction and/or disabling condition in head or trunk?

☒ **No** ☐ **Yes**

If yes, place a check mark in each applicable box; specify other observations.

	Side to Side	Flexion	Extension	Other Observations
a. Head				
b.Trunk				

PHYSICAL FUNCTION (Cont'd)

Appraisal Number

1	2	3	4	5	6
☒	☐	☐	☐	☐	☐

PATIENT ID NUMBER

0 0 0 0 0 0 0 0 0

B. Strength, Balance, and Coordination

Note—(1) If the client is bed-bound or chair-bound, complete only those test items that can be performed under those conditions; (2) observe balance and coordination (Item 7-8) while testing items 1-6; (3) perform tests and check as applicable; and (4) specify other observations.

1. Patient can dorsiflex foot, and with knee extended, raise leg 10 inches from bed, hold 5 seconds, lower to bed.
   Right Leg: ☒ Yes ☐ No Left Leg: ☐ Yes ☒ No
   Other Observations _____
2. Patient can roll from supine to prone in each direction.
   Right to Left: ☒ Yes ☐ No Left to Right: ☒ Yes ☐ No
   Other Observations Seems afraid to roll for fear of falling out of Bed. Has periodic pain in (R) hip
3. Patient can sit up unassisted, swing legs over side of bed and return. ☐ Yes ☒ No
   Other Observations Can swing Leg on (R) side
4. Patient can grasp examiner's hand with normal strength hand grip.
   Right Hand: ☒ Yes ☐ No Left Hand: ☒ Yes ☐ No
   Other Observations _____
5. Patient can stand erect having used chair arms for support. ☐ Yes ☒ No
   Other Observations Unable to stand
6. Patient can stand erect unsupported, and with elbows extended, raise both arms above head, hold for 5 seconds.
   ☐ Yes ☒ No
   Other Observations Unable to stand
7. Patient appears to have normal balance when sitting unsupported and standing unsupported.
   Sitting: ☒ Yes ☐ No Standing: ☐ Yes ☒ No
   Other Observations Unable to Stand
8. Patient appears to have normal coordination when moving body parts. ☒ Yes ☐ No
   Other Observations _____

Review questions in Section A—Range of Motion and Section B—Strength, Balance, and Coordination. If any restrictions and/or impairments are observed, the patient should be seen by a physical or occupational therapist for a more thorough examination.

C. Activities of Daily Living

Indicate the level of performance by placing a check in every column that applies. Think of these functional abilities in relation to the individual's rehabilitation potential when answering parts of question 5 on page 3 of this instrument.

FUNCTION	A NO PROBLEM	B MECHANICAL AID	C HUMAN HELP	D # PERSONS HELPING	E DOES NOT PERFORM	F. REMARKS
1. MOBILITY						
a. Goes Outside					X	Rehab Potential Good
b. Walking					X	" " "
c. Climbing Stairs					X	" " "
d. Transferring			X	1		
e. Wheeling	X					
2. PERSONAL CARE						
a. Bathes/Showers			X	1		" " "
b. Toileting			X	1		" " "
c. Dressing			X	1		" " "
d. Grooming	X					
e. Eating	X					

DENTAL/ORAL STATUS

SAMPLE
(See instructions pp. 96-97)

Appraisal Number

1	2	3	4	5	6
☒	☐	☐	☐	☐	☐

Use a tongue depressor or dental mirror and flashlight to make the examination. Check all boxes that apply and record other problems in space provided to describe condition of the mouth. (See instructions pp. 96-97)

	None	1-10	11+	Satisfactory	Decay	Fracture	Pain	Loose	Unclean
Natural Teeth		✓							•
Dentures Complete or Partial	None	Upper / Uses	Lower / Uses	Satisfactory	Broken	Missing Teeth	Uncomfortable	Loose	Unclean
		Partial / No	Complete / yes						
Oral Soft Tissues	Normal	Gums Inflamed	Dry Mouth		Ulcer, Sore, Lump, or Other Lesion				
				Tongue	Under Tongue	Lips	Palate	Cheeks	Gums

Other Dental/Oral Problems Has plaque deposits. Patient cleans own teeth. Upper partial lost.

NUTRITIONAL STATUS

See Instructions pp. 97-99

1. Is there a special diet prescribed?
   ☐ No ☒ Yes
   If yes, check appropriate diet(s) listed below.
   ☒ a. Mechanical Soft Diet
   ☐ b. Bland-Low Residue Diet
   ☐ c. Diabetic Diet
   ☐ d. Calorie Restricted Diet
   Specify calorie level _____
   ☐ e. Sodium Restricted Diet
   ☐ f. Fat Modified Diet
   ☐ g. Other, specify _____
2. Is there an intake problem?
   ☐ No ☒ Yes
   If yes, check those that apply below.
   ☒ a. Solid Food Problem (Specify) Difficulty in chewing, upper denture missing, no appetite, picky eater
   ☐ b. Fluid Intake Problem (Specify) _____
3. Is there an output problem?
   ☒ No ☐ Yes
   If yes, check those that apply below.
   ☐ a. Constipation
   ☐ b. Diarrhea
   ☐ c. Fluid Retention
   ☐ d. Other (Specify) _____
4. Are there food likes or dislikes?
   ☐ No ☒ Yes
   If yes, complete the folowing:
   a Are they recorded? ☒ Yes ☐ No
   b. Are they carried out? ☐ Yes ☒ No not completely - Not a Kosher kitchen
5. Are there cultural/religious constraints? ☐ No ☒ Yes
   If yes, complete the folowing:
   a. Are they recorded? ☒ Yes ☐ No
   b. Are they carried out? ☐ Yes ☒ No Note above
6. Are supplementary nourishments given, e.g., a high protein commercial preparation ☐ No ☒ Yes
   If yes, specify ENSURE, 240 cc T.i.d.
7. What is the usual dining location? Dining room
8. Weight (this appraisal) 120
9. Has there been a recent weight change? ☐ No ☒ Yes
   If yes, specify whether gain or loss and how much. Loss - 16 lbs.

Case CC-13
Appraisal I

PSYCHOSOCIAL FACTORS

SAMPLE
See Instructions pp. 99-102

Appraisal Number
1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

PATIENT ID NUMBER
[0][0][0][0][0][0][0][0][0]

A. Patient's Adjustment to Care Plan
Note: The following items may not be applicable to a newly admitted patient. If care plan has not been developed on first appraisal, omit this item and write N.A. in the margin. Complete on subsequent appraisals when care plan has been developed.

ITEM	PATIENT		FAMILY/SURROGATE	
	YES	NO	YES	NO
1. Involved in care planning				
2. Cooperated actively—with positive attitude and enthusiasm		N/A		
3. Cooperated passively—made no inputs, but carried out plan			Appraisal #1	
4. Found fault with some items in the care plan but followed plan				
5. Found fault with items in the care plan and refused to cooperate				
6. Was provided with an educational experience explaining the rationale for the treatment and care plan				

B. Patient's Social Interaction and Adjustments to the Facility
Describe the pattern of behavior for the individual by checking the appropriate column for each item

ITEM	USUALLY	OCCASIONALLY	NEVER
1. Is oriented to the time and space of his/her living environment.	✓		
2. Cooperates with rules and regulations.	✓		
3. Asserts self and makes needs known.	✓		
4. Participates in self-directed activities.		✓	
5. Personalizes living space.		✓	
6. Personalizes apparel.	✓		
7. Participates in structured activity program.			✓
8. Eats in dining room (if physically capable).	✓		
9. Spends free time outside his/her own room.		✓	
10. Has visitors from outside the facility.	✓		
11. Visits others outside the facility.			✓
12. Has outside contacts, i.e., letters, calls, etc..		✓	
13. Talks about events that go on outside the facility.		✓	
14. Engages in conversation with staff.		✓	
15. Engages in conversation with fellow patients.		✓	
16. Relates in an appropriate adult manner to fellow patients.	✓		
17. Relates in an appropriate adult manner to staff.	✓		

C. Behavioral Problems

Describe the usual manner of behavior for the individual by checking the appropriate column for each item (1-15). Indicate in Column A those behaviors which have not been exhibited; and in Column B those that have been exhibited by the patient and specify by checking the appropriate box which of those behaviors interfere with the functional capacity, require special care, and/or supervision. (See definitions pp. 102-103)

BEHAVIORS	(A) DOES NOT EXHIBIT	(B) EXHIBITS	
		DOES NOT INTERFERE	INTERFERES
1. Apprehensive			✓
2. Withdrawn			✓
3. Hyperactive	✓		
4. Abusive to self	✓		
5. Disruptive	✓		
6. Hostile	✓		
7. Abusive to others	✓		
8. Wanders	✓		
9. Forgetful	✓		
10. Confused			✓
11. Delusional	✓		
12. Hallucinates	✓		
13. Emotionally labile	✓		
14. Depressed			✓
15. Inappropriate behavior, other specify _____			

If the individual's adjustment to the care plan, his/her social interaction and adjustment to the facility, or behavioral characteristics affect his/her functional capacity or necessitate additional care and/or supervision, then consideration should be given to having the patient examined by a psychiatrically oriented professional such as a psychiatric or other qualified social worker, psychiatric nurse, clinical psychologist or psychiatrist.

The patient looks back on her fall and hip fracture as a "crisis."

PATIENT CARE

SAMPLE
See Instructions pp. 103--109

Appraisal Number

1	2	3	4	5	6
☒	☐	☐	☐	☐	☐

A. Special Procedures
For each procedure listed below, check those given at the time of this appraisal, and indicate the frequency performed and by whom.

	PROCEDURE	FREQUENCY	BY WHOM
General Nursing Care	☒ 1. Preventive Skin Care	b.i.d.	Nurse's Aide
	☐ 2. Decubitus Care		
	☐ 3. Sterile Protective Dressings		
	☒ 4. Turning Schedule or Repositioning	q 2 hours	self, Nurse's Aide
	☐ 5. Oxygen Rx		
	☐ 6. Inhalation IPPB		
	☐ 7. Suctioning		
	☐ 8. Irrigation--Bladder		
	☐ 9. Irrigation--Other than Bladder		
	☐ 10. Ostomy Care		
	☐ 11. Enemas		
	☐ 12. Hydrotherapy (e.g., Whirlpool Baths, Soaks)		
	☐ 13. Maintenance Ambulation		
	☐ 14. Restraints		
	☐ 15. Other (Specify)		
Rehabilitation/Restorative	☐ 16. Speech Pathology/Audiology		
	☐ 17. Bowel Training		
	☐ 18. Bladder Training		
	☒ 19. Passive Exercises	q.d.	P.T., RN
	☐ 20. Transfer Skills Training	q.d.	P.T., RN
	☐ 21. Active Exercises		
	☐ 22. Resistive Weight Lifting Exercises		
	☐ 23. Gait Training		
	☐ 24. Prosthetic Training		
	☐ 25. Other (Specify)		
Teaching	☐ 26. Diet Instruction		
	☐ 27. Ostomy Care (Type)		
	☐ 28. Foot Care		
	☐ 29. Self Injection		
	☐ 30. Other (Specify)		
Psychosocial	☒ 31. Self-directed Activities	q.d.	self
	☐ 32. Group Activities		
	☒ 33. Religious Activities	1 x week	R.N.
	☐ 34. Reality Orientation Therapy		
	☐ 35. Remotivation Therapy		
	☐ 36. Behavior Modification Therapy		
	☐ 37. Social Counseling		
	☐ 38. Other (Specify)		

PATIENT CARE (Cont'd)

SAMPLE

B. Professional Visits

Was a professional visit by the attending physician or a consultant made to the patient/resident during this appraisal period.

☐ No ☒ Yes

If yes, indicate below the date(s) on which such visits were made.

		DATE(S)
☒	1. Attending Physician (M.D. or D.O.)	9/1/77
☐	2. Consultant Physician (M.D. or D.O.)	
☐	3. Dentist	
☐	4. Optometrist or Ophthalmologist	
☐	5. Speech Pathologist/Audiologist	
☐	6. Psychologist	
☐	7. Podiatrist	
☐	8. Other (Specify) _____	

C. Medications

In the following chart, identify by name, the medication in each category actually given on the day chosen for review. Record the unit dosage (e.g., 65 mg., ii tab., 10 units, etc.), the number of times the drug was given (e.g., 1, 3, 6, etc.), and the route of administration (e.g., p.o., (H), etc.). See Appendix B. Drug Classification Guide for explanation of categories.

CATEGORY	NAME	DOSAGE	# OF TIMES	ROUTE OF ADMIN.
1. Adrenal Cortical Hormones, etc.				
2. Analgesics	Aspirin	gr. X	1 X	p.o.
3. Antacids				
4. Anticoagulants				
5. Anticonvulsants				
6. Antidepressants				
7. Antidiarrheals				
8. Antihistamines				
9. Antihypertensives				
10. Anti-infectives				
11. Anti-Parkinsonism Agents				
12. Bronchodilators				
13. Cardiac Drugs	Nitro Bid	2.5 mg	1 X	p.o.
	Nitroglycerin	1 tab	1 X	Subling.
14. Cathartics				
15. Diuretics				
16. Electrolyte/Fluid Replacements				
17. Estrogens/Androgens				
18. Expectorants/Cough Preparations				
19. EENT Preparations				
20. Insulin/Antidiabetic Agents				
21. Narcotic Analgesics	Demerol	50 mg	4x	I.M.
22. Sedatives/Hypnotics				
23. Skin/Mucous Membranes				
24. Spasmolytics/Antispasmodics				
25 Stimulants				
26. Thyroid Replacements				
27. Tranquilizers				
28. Vasodilating Agents				
29. Vitamins/Minerals				
30. Other				
31. Additional Drugs/Category: *(Use Categories 1-29 above)*				

Total # of Medications: 4
Total # Given by IM or IV or Subcutaneous route: 1
Total # Given that require additional supervision or care: 2
Date of Day Chosen for Appraisal Review 9 / 7 / 77
month day year

Since last appraisal, were there any manisfestations of undesired side effects or toxicity due to medications including allergic reaction, interactions, drug dependence, etc.

☐ No ☒ Yes

If yes, specify type, time of occurrence, and steps taken to alleviate the problem Confused at night- Check relationship to MEDs, Discuss at CARE PLANNING SESSION

When was the last time medications were reviewed? Date: 9 / 1 / 77
month day year

By whom were medications reviewed? (Check all that apply)

☒ Pharmacist ☐ Physician ☒ Nurse REVIEWED TOGETHER
☐ Other, specify

Case CC-16

SCHEDULE A

MEDICAL DATA

SAMPLE

Appraisal Number

1 ☒ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER

0 0 0 0 0 0 0 0 0

1. Medically Defined Conditions

Indicate below any new or reactive medically defined conditions not identified at time of admission or first appraisal. Follow approved medical record keeping system of your institution and State, such as the use of ICDA-9-CM Classification Codes. Give date of onset of condition and include as appropriate in next care plan.

CLASS.	DIAGNOSIS	DATE OF ONSET	COMMENTS

2. Medical Status Measurements (Record new additional test findings after first appraisal).

TEST	DATE/READING	DATE/READING	DATE/READING	DATE/READING
Body Weight	9/4/118	10/13/119	10/31/119	

SCHEDULE B
SKIN

Case CC-17
Case CC: Appraisal I

SAMPLE

Appraisal Number

1 [X] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ]

PATIENT ID NUMBER

0 0 0 0 0 0 0 0 0

For each site of a decubitus ulcer or abnormality identified, complete one section of the charts as follows: (1) record the diameter in cms.; (2) the depth as (s) shallow or (d) deep; and (3) the status as (c) clean or (p) purulent.

1. Site	Date of Appraisal	Date of Appraisal	Date of Appraisal	Date of Appraisal	Date of Appraisal
1) Diameter					
2) Depth					
3) Status					
2. Site	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**
1) Diameter					
2) Depth					
3) Status					
3. Site	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**
1) Diameter					
2) Depth					
3) Status					

Provide detail of any other skin abnormality including type such as dryness, redness, inflammation or infection, rash, or injury (abrasion, laceration, etc.) site and date of onset.

9/7/77 - Coccyx/reddened skin, 2cm diameter - skin intact

Case CC-18
Care Planning
Session I

Sept. 9, '77 (Care Planning Session #1)

Mrs. Crenski's health care team meets, and from her appraisal data, extracts her problems and set their priority of care. Each problem's goal, target date, and plan of care is decided and recorded on the following Care Planning form #1. Each imparment, goal, and its target date are recorded on the Goal Achievement Summary form #1

The date scheduled for the next health care team's care evaluation and planning session is recorded.

Case CC-19
Care Planning
Session I

Care Planning Session #1

Note how problem extraction and problem prioritizing are recorded.

1) Carefully read through Catherine Crenski's initial appraisal.
2) Flag problems as they appear in each section.
3) Note the problems and list them in the space for notes below.
4) Based on what information you have, decide the order of priority of Mrs. Crenski's problems.
5) Review the PACE Problem/Impairment/Dysfunctions provided on the Care Planning Form.

Case CC-20
Care Planning
Session I

Care Planning Session #1: Care Planning Form,
Care Evaluation Form

Decide what the plan of care might be if this patient were in your facility.

1) Using a PACE Care Planning Practice Worksheet, record the problem, the goal which you might try to reach, by what date, and the plan of care to reach that goal. A Care Planning Worksheet is found on the following page.

To more closely simulate an actual care planning meeting, a group of PACE training students may wish to work together to develop a care plan from Catherine Crenski's actual appraisal and appraisal summary.

2) Tailor the Care Plan to fit your own facility's physical and professional resources.
3) Start the Care Evaluation practice by using the Goal Achievement Summary Worksheet found on the following page, by recording each long range, or, short term goal, and its target date.

4) Compare your own care plan with the actual care plan #1 developed for this patient found on the following pages.

5) Note how your care plan differs from the actual care plan. For each difference, either mentally or in writing in the space below, give the rationale for your care planning as you would articulate your reasoning in an actual care planning meeting.

6) Compare the Goal Achievement Summary which you have prepared with the actual PACE Goal Achievement Summary #1 developed for Catherine Crenski.

Case CC-22
Care Planning
Session I

Patient's Name _____ Date Care Planning Session ____/____/____ Session No. _____
Month Day Year

Patient's ID Number | | | | | | | | | | Date Appraisal Completed ____/____/____ Team Present _____
Month Day Year

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM

Date Next Care Planning Session ____/____/____
Month Day Year

Patient's Name Catherine Crenski

Patient's ID Number 0 0 0 0 0 0 0 0 0

Date Care Planning Session 9 / 8 / 77 (Month / Day / Year)

Date Appraisal Completed 9 / 9 / 77 (Month / Day / Year)

Session No. 1

Team Present R.N., P.T., S.W., Diet., Aide

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM
Dx: Fracture of Left femur with pin 1) Inability to walk or stand	Transferring from Bed to Chair to walker by self; Ambulatory w/ walker	10/4/77	Evaluate and establish plan of care for weight bearing & ambulation	1	P.T.
2) Pain on movement	Eliminate pain on movement as indicated by reduction in use of Demeral	10/4/77	Passive range of motion	b.i.d.	PT/RN/LPN
3) Reddened area over Coccyx	Eliminate redness	10/4/77	Turn and/or patient turn self frequently. Back care including massage of reddened area.	P.r.n.	Aide
4) Possible drug dependence	Decrease Demeral to 25 mg q. 4/hr. 2x daily max. or max. of 50 mg/day	10/4/77	Monitor for change	T.i.d.	R.N.
Dietary Problems: 5) Nutritional anemia/ poor appetite	Balanced adequate diet w/no weight gain	10/4/77	Dietary counselling; Weight q. 2 weeks	1x	Diet.
6) Difficulty Chewing	Replace lost dentures	10/4/77	Dental consultation	1x	Dentist

Date Next Care Planning Session 10 / 5 / 77 (Month / Day / Year)

Case CC-24
Care Planning
Session I

Patient's Name Catherine Crenski

Patient's ID Number 0 0 0 0 0 0 0 0 0

Date Care Planning Session 9 / 8 / 77 (Month / Day / Year)

Date Appraisal Completed 9 / 9 / 77 (Month / Day / Year)

Session No. 1

Team Present R.N., P.T., S.W., Diet., Aide

CARE PLANNING

Page 2

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM
Dx: Osteoarthritis - Bilateral hands and wrists 7. Pain in hands and wrists 8. Reduced ROM in hands and wrists	7&8: Increase ROM to permit activities such as letter writing and hand craft	10/4/77	7&8: Passive and Active exercise	b.i.d.	R.N.
Dx: Angina 9. Chest pain	Maintain present status	Ongoing	Monitor for change	q.d.	R.N.
Psychosocial status 10. Apprehensive 11. Withdrawn 12. Confused 13. Depressed	10-13: Reduce apprehension, withdrawal, Confusion & depression Decrease dependence on Demeral	10/4/77	10-13: Staff to spend more time interacting with patient and encouraging her to engage in activities. Contact Rabbi	q.d. 1x	RN, LPN, Aide R.N.

Date Next Care Planning Session 10 / 5 / 77 (Month / Day / Year)

Case CC-25
Care Planning
Session I

Patient's Name Catherine Crenski Patient's ID Number 000-00-0000 Summary No. 1

Date Care Planning Session 9/8/77

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		
1.	Transferring from bed to chair to walker by self & ambulating w/ walker.	10/4	10/4			X	X			Work toward walking w/out human help or mechanical aid
2.	Eliminate pain on movement as indicated by reduction in use of Demerol	10/4	10/4		X		X			Patient occassionally uncooperative in carrying out exercises
3.	Eliminate reddened area over Coccyx	10/4	10/4			X	X			Coccyx no longer red
4.	Decrease Demerol to 25 mg q. 4 hr. 2x daily max.	10/4	10/4		X		X			Patient still requesting Demerol more often on some days.
5.	Balanced daily diet w/ no weight gain	10/4	10/4		X		X			Tot. gain 1 lb. Kosher food still not available

Patient's Name Catherine Crenski Patient's ID Number 000-00-0000 Summary No. 1

Date Care Planning Session 9/8/77

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		
6.	Replace lost dentures	10/4	10/4			X	X			Patient has new partial dentures. Teeth cleaned.
7.	Increase ROM to permit activities such as letter writing & hand crafts.	10/4	10/4		X		X			Patient occasionally uncooperative in carrying out exercise.
8.	Maintain present status re: angina attacks	ongoing	10/4			X	X			Patient experiences 1-2 angina attacks per week
9.	Reduce apprehension, withdrawal, confusion & depression	10/4	10/4		X		X			Patient using Demerol less often. Confusion lessened. Apprehension, withdrawal & depression improved with participation in more activities.

Case CC-27
Care Planning
Session I

Patient's Name _____ Patient's ID Number _____ Summary No. _____

Date Care Planning Session _____

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		

Sept. 29, '77

Mrs. Crenski's reappraisal (Appraisal II) is begun.

Oct. 4, '77

Mrs. Crenski's reappraisal (Appraisal II) is completed

Carefully read her reappraisal (Appraisal II) data found on the following pages. Please note that although physician's orders are not listed, they are reflected on the PACE form, such as on the medication review sheet for Appraisal II.

List any points to be clarified below:

Case CC-29
Appraisal II

PATIENT APPRAISAL DATA

SAMPLE
See Instructions pp. 53-54

Appraisal Number
1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER
0 0 0 0 0 0 0 0 0

PACE APPRAISER: Jane Doe, R.N.
Name and Discipline

Beginning Date of Appraisal 9/29/77

Type of Appraisal ☐ Admission/Initial ☒ Periodic
☐ Routine (Annual) ☐ Discharge
☐ Other (Specify) _____

1. Present Level of Care (Check appropriate box)
   ☑ Skilled Nursing Care
   ☐ Intermediate Care
   ☐ Other (Specify) _____
2. Present Reimbursement Source(s). Indicate in the space provided whether (P) principal or (S) supplemental; (unless a change has occurred since last appraisal, omit this question).
   - ✓ Medicare (Title XVIII)
   - _____ Medicaid (Title XIX)
   - _____ Social Services (Title XX)
   - _____ V.A.
   - _____ Workers' Compensation
   - _____ All Other Public Sources
   - ✓ Blue Cross or Commercial Health Insurance
   - _____ Self Pay
   - _____ No Charge
   - _____ Not Determined
3. Have any incidents or accidents occurred involving this patient since the last appraisal?
   ☑ No ☐ Yes
   If yes, give details
4. Has there been a significant change in the individual's physical or emotional status since the last appraisal?
   ☑ No ☐ Yes
   If yes, give details _____
5. Rehabilitation Potential:
   a. Is there a possibility of restoring the indivdual from his/her present physical and/or emotional functional level to a higher level of function? (check appropriate box)
      ☐ No ☒ Yes
   b. If yes, explain in what functional areas this is possible Mobility, climbing stairs, independent ambulation out of building.
   c. If no, is there a possibility of preventing deterioration of the present physical and/or emotional state to sustain the individual's current capacities? (check appropriate box)
      ☐ No ☐ Yes
   d. If yes, specify the functional areas _____
   e. If no, is there a possibility of slowing down the process of deterioration? (check appropriate box)
      ☐ No ☐ Yes
   f. If yes, specify the functional areas _____
6. If improving, is discharge anticipated within one month?
   ☒ No ☐ Yes
   If yes, complete Schedule C.

Fill in this section at end of appraisal.
Check appropriate box(es) indicating the professional discipline of persons contributing to this appraisal:

- ☑ R.N.
- ☑ L.P.N.
- ☑ Aide/Orderly
- ☐ Other, specify _____
- ☐ Social Worker
- ☑ Physical Therapist
- ☐ Occupational Therapist

PACE Appraiser's signature Jane Doe, R.N.

Date of Completion of Appraisal: 10 / 4 / 77
month day year

Case CC-31
Appraisal II

IMPAIRMENTS

SAMPLE
See Instructions pp. 54-58

Appraisal Number
1 ☐ 2 ☑ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER
0 0 0 0 0 0 0 0 0

A. Skin

1. **Are there any decubitus ulcers present at this appraisal:** ☒ **No** ☐ **Yes**
   If yes, indicate number of sites _____
2. Are there any other skin abnormalities: ☒ **No** ☐ **Yes**

If Item 1 and/or 2 is answered yes, complete Schedule B.

B. Extremities and Trunk

Are there any missing limbs or fracture/dislocation of the hip or other bone: ☐ **No** ☐ **Yes**
If yes, complete the following chart.

EXTREMITY		MISSING LIMBS Date of amputation, and Type: (BE) Below Elbow (AK) Above Knee (AE) Above Elbow (P) Prosthesis (BK) Below Knee	FRACTURED HIP(S) Date of Repair (R) or Prosthesis	OTHER FRACTURES/ DISLOCATIONS Date and Location
UPPER	R			
	L			
LOWER	R			
	L		Ex ⓛ femur 8/11/77	

C. Sensory/Communication Status (check appropriate box(es)).

1. Vision (with glasses if customarily used)
   ☒ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
   ☐ **b. Moderate loss** ☐ **d. Total blindness**
2. Hearing (with hearing aid if customarily used)
   ☒ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
   ☐ **b. Moderate loss** ☐ **d. Total deafness**
3. Expressive Communication
   Select the one category that best describes the **usual** method used by the patient in conveying information.
   ☒ **a. Speaks and is usually understood** ☐ **d. Uses gestures, grunts, or primitive symbols**
   ☐ **b. Speaks but is understood only with difficulty** ☐ **e. Does not convey needs**
   ☐ **c. Uses structured sign language, symbol board, or writes** ☐ **f. Not determined**
4. Receptive Communication
   Select the one category that best describes the patient's **usual** method of understanding information conveyed by others.
   ☒ **a. Hears and usually understands** ☐ **e. Does not understand**
   ☐ **b. Hears and understands only with difficulty** ☐ **f. Not determined**
   ☐ **c. Depends on lip reading, written materials, or structured sign language**
   ☐ **d. Understands only primitive gestures, facial expressions or simple pictograms and/or recognizes environmental cues**

D. Bowel/Bladder Status

1. Is there bowel incontinence:
   ☒ **No** ☐ **Yes**
   If yes, specify frequency of incidents _____
2. Are there any other bowel problems such as ostomy:
   ☒ **No** ☐ **Yes**
   If yes, specify _____
   If yes, is assistance needed? ☐ **No** ☐ **Yes**
3. Is there bladder incontinence:
   ☒ **No** ☐ **Yes**
   If yes, specify frequency of incidents _____
4. Are there any other bladder problems such as ostomy, indwelling catheter or external device:
   ☒ **No** ☐ **Yes**
   If yes, specify _____
   If yes, is assistance needed? ☐ **No** ☐ **Yes**

PHYSICAL FUNCTION

Appraisal Number

1	2	3	4	5	6
☐	☒	☐	☐	☐	☐

Note—During any of the specified tests in Section A—Range of Motion and Section B—Strength, Balance, and Coordination, if the client indicates pain on motion, stop that portion of the test immediately. Proceed to another test. If tests in these sections are medically contraindicated, give reasons:

_____ Date ___/___/___

_____ Date ___/___/___

A. Range of Motion

With patient lying on back on bed, test passive movements of upper and lower extremities for full range of motion. Indicate by check in the chart below if there is restriction and/or disabling condition in any extremity. Specify other observations in the space provided.

RESTRICTED

PARTS OF THE BODY	FLEXION A	EXTENSION B	ABDUCTION C	ADDUCTION D	ROTATION E	OTHER OBSERVATIONS F.
1. Right Extremities						
a. Fingers/Thumb	✓	✓				
b. Wrist	✓	✓				
c. Elbow						
d. Shoulder						
e. Ankle						
f. Knee						
g. Hip						
2. Left Extremities						
a. Fingers/Thumb	✓	✓				
b. Wrist	✓	✓				
c. Elbow						
d. Shoulder						
e. Ankle						
f. Knee	✓	✓				
g. Hip	✓	✓	✓	✓	✓	

3. Head and Trunk

With patient sitting unsupported on side of bed, test range of motion of head and trunk. If patient cannot sit unsupported on side of bed for any reason, indicate in the margin that the test was not done. If appropriate, complete test at a later date.

Is there any restriction and/or disabling condition in head or trunk?

☒ **No** ☐ **Yes**

If yes, place a check mark in each applicable box; specify other observations.

	Side to Side	Flexion	Extension	Other Observations
a. Head				
b.Trunk				

PHYSICAL FUNCTION (Cont'd)

SAMPLE

Appraisal Number
1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER
0 0 0 0 0 0 0 0 9

B. Strength, Balance, and Coordination

Note—(1) If the client is bed-bound or chair-bound, complete only those test items that can be performed under those conditions; (2) observe balance and coordination (Item 7-8) while testing items 1-6; (3) perform tests and check as applicable; and (4) specify other observations.

1. Patient can dorsiflex foot, and with knee extended, raise leg 10 inches from bed, hold 5 seconds, lower to bed.
   Right Leg: ☒ Yes ☐ No Left Leg: ☐ Yes ☒ No Same weakness
   Other Observations _____
2. Patient can roll from supine to prone in each direction.
   Right to Left: ☒ Yes ☐ No Left to Right: ☒ Yes ☐ No
   Other Observations Still fearful of falling. Has pain in (L) hip
3. Patient can sit up unassisted, swing legs over side of bed and return. ☐ Yes ☐ No
   Other Observations Still weak
4. Patient can grasp examiner's hand with normal strength hand grip.
   Right Hand: ☒ Yes ☐ No Left Hand: ☒ Yes ☐ No
   Other Observations _____
5. Patient can stand erect having used chair arms for support. ☐ Yes ☒ No
   Other Observations Still weak
6. Patient can stand erect unsupported, and with elbows extended, raise both arms above head, hold for 5 seconds.
   ☐ Yes ☐ No
   Other Observations Beginning to stand
7. Patient appears to have normal balance when sitting unsupported and standing unsupported.
   Sitting: ☒ Yes ☐ No Standing: ☐ Yes ☒ No
   Other Observations _____
8. Patient appears to have normal coordination when moving body parts. ☒ Yes ☐ No
   Other Observations _____

Review questions in Section A—Range of Motion and Section B—Strength, Balance, and Coordination. If any restrictions and/or impairments are observed, the patient should be seen by a physical or occupational therapist for a more thorough examination.

C. Activities of Daily Living

Indicate the level of performance by placing a check in every column that applies. Think of these functional abilities in relation to the individual's rehabilitation potential when answering parts of question 5 on page 3 of this instrument.

FUNCTION	A NO PROBLEM	B MECHANICAL AID	C HUMAN HELP	D # PERSONS HELPING	E DOES NOT PERFORM	F. REMARKS
1. MOBILITY						
a. Goes Outside					✓	Taken outside x1 to dentist
b. Walking		✓				
c. Climbing Stairs					✓	
d. Transferring			✓	1		
e. Wheeling	✓					
2. PERSONAL CARE						
a. Bathes/Showers			✓	1		Wants to shower ē help - seated
b. Toileting			✓	1		
c. Dressing			✓	1		
d. Grooming	✓					
e. Eating	✓					

DENTAL/ORAL STATUS

SAMPLE

Appraisal Number

1 ☐ 2 ☒ 3 ☐ 4 ☐ 5 ☐ 6 ☐

Use a tongue depressor or dental mirror and flashlight to make the examination. Check all boxes that apply and record other problems in space provided to describe condition of the mouth. (See Instructions pp. 96-97)

Natural Teeth	None ☐	1-10 ☐	11+ ☐	Satisfactory ☐	Decay ☐	Fracture ☐	Pain ☐	Loose ☐	Unclean ☐
Dentures Complete or Partial	None ☐	Upper Uses Partial yes ☐	Lower Uses Complete yes ☐	Satisfactory ☐	Broken ☐	Missing Teeth ☐	Uncomfortable ☐	Loose ☐	Unclean ☐
Oral Soft Tissues	Normal ☐	Gums Inflamed ☐	Dry Mouth ☐	Ulcer, Sore, Lump, or Other Lesion					
				Tongue ☐	Under Tongue ☐	Lips ☐	Palate ☐	Cheeks ☐	Gums ☐

Other Dental/Oral Problems Patient has new partial dentures and teeth were cleaned by dentist.

NUTRITIONAL STATUS

See Instructions pp. 97-99

1. Is there a special diet prescribed?
   ☒ **No** ☐ **Yes**
   If yes, check appropriate diet(s) listed below.
   - ☐ **a. Mechanical Soft Diet**
   - ☐ **b. Bland-Low Residue Diet**
   - ☐ **c. Diabetic Diet**
   - ☐ **d. Calorie Restricted Diet**
     Specify calorie level _____
   - ☐ **e. Sodium Restricted Diet**
   - ☐ **f. Fat Modified Diet**
   - ☐ **g. Other, specify** _____
2. Is there an intake problem?
   ☐ **No** ☒ **Yes**
   If yes, check those that apply below.
   - ☐ **a. Solid Food Problem (Specify)** _____
   - ☐ **b. Fluid Intake Problem (Specify)** _____
3. Is there an output problem?
   ☒ **No** ☐ **Yes**
   If yes, check those that apply below.
   - ☐ **a. Constipation**
   - ☐ **b. Diarrhea**
   - ☐ **c. Fluid Retention**
   - ☐ **d. Other (Specify)** _____
4. Are there food likes or dislikes?
   ☐ **No** ☒ **Yes**
   If yes, complete the following:
   a. Are they recorded? ☒ **Yes** ☐ **No**
   b. Are they carried out? ☐ **Yes** ☒ **No** Kosher food needed
5. Are there cultural/religious constraints? ☐ **No** ☒ **Yes**
   If yes, complete the following:
   a. Are they recorded? ☒ **Yes** ☐ **No**
   b. Are they carried out? ☐ **Yes** ☒ **No** Kosher food not available
6. Are supplementary nourishments given, e.g., a high protein commercial preparation ☐ **No** ☒ **Yes**
   If yes, specify Ensure 240 cc. TID
7. What is the usual dining location? dining room
8. Weight (this appraisal) 119
9. Has there been a recent weight change? ☐ **No** ☒ **Yes**
   If yes, specify whether gain or loss and how much. gained 1 lb., appetite improving

PSYCHOSOCIAL FACTORS

SAMPLE
See Instructions pp. 99-102

Appraisal Number

1	2	3	4	5	6
☐	☒	☐	☐	☐	☐

PATIENT ID NUMBER

0	0	0	0	0	0	0	0	0

A. Patient's Adjustment to Care Plan

Note: The following items may not be applicable to a newly admitted patient. If care plan has not been developed on first appraisal, omit this item and write N.A. in the margin. Complete on subsequent appraisals when care plan has been developed.

ITEM	PATIENT		FAMILY/SURROGATE	
	YES	NO	YES	NO
1. Involved in care planning	✓		✓	
2. Cooperated actively—with positive attitude and enthusiasm	✓		✓	
3. Cooperated passively—made no inputs, but carried out plan		✓		
4. Found fault with some items in the care plan but followed plan				
5. Found fault with items in the care plan and refused to cooperate		✓		
6. Was provided with an educational experience explaining the rationale for the treatment and care plan	✓		✓	

B. Patient's Social Interaction and Adjustments to the Facility

Describe the pattern of behavior for the individual by checking the appropriate column for each item.

ITEM	USUALLY	OCCASIONALLY	NEVER
1. Is oriented to the time and space of his/her living environment.	✓		
2. Cooperates with rules and regulations.	✓		
3. Asserts self and makes needs known.	✓		
4. Participates in self-directed activities.		✓	
5. Personalizes living space.	✓		
6. Personalizes apparel.	✓		
7. Participates in structured activity program.		✓	
8. Eats in dining room (if physically capable).	✓		
9. Spends free time outside his/her own room.		✓	
10. Has visitors from outside the facility.	✓		
11. Visits others outside the facility.		✓	
12. Has outside contacts, i.e., letters, calls, etc.		✓	
13. Talks about events that go on outside the facility.	✓		
14. Engages in conversation with staff.	✓		
15. Engages in conversation with fellow patients.	✓		
16. Relates in an appropriate adult manner to fellow patients.	✓		
17. Relates in an appropriate adult manner to staff.	✓		

C. Behavioral Problems

Describe the usual manner of behavior for the individual by checking the appropriate column for each item (1-15). Indicate in Column A those behaviors which have not been exhibited; and in Column B those that have been exhibited by the patient and specify by checking the appropriate box which of those behaviors interfere with the functional capacity, require special care, and/or supervision.

BEHAVIORS	(A) DOES NOT EXHIBIT	(B) EXHIBITS	
		DOES NOT INTERFERE	INTERFERES
1. Apprehensive		✓	
2. Withdrawn		✓	
3. Hyperactive	✓		
4. Abusive to self	✓		
5. Disruptive	✓		
6. Hostile	✓		
7. Abusive to others	✓		
8. Wanders	✓		
9. Forgetful	✓		
10. Confused	✓		
11. Delusional	✓		
12. Hallucinates	✓		
13. Emotionally labile	✓		
14. Depressed		✓	
15. Inappropriate behavior, other specify _____			

If the individual's adjustment to the care plan, his/her social interaction and adjustment to the facility, or behavioral characteristics affect his/her functional capacity or necessitate additional care and/or supervision, then consideration should be given to having the patient examined by a psychiatrically oriented professional such as a psychiatric or other qualified social worker, psychiatric nurse, clinical psychologist or psychiatrist.

—8—

Previous problems of apprehension, being withdrawn and depression have improved.

PATIENT CARE

SAMPLE
See Instructions pp. 103-107

Appraisal Number

1	2	3	4	5	6
☐	☒	☐	☐	☐	☐

A. Special Procedures

For each procedure listed below, check those given at the time of this appraisal, and indicate the frequency performed and by whom.

	PROCEDURE	FREQUENCY	BY WHOM
General Nursing Care	☐ 1. Preventive Skin Care		
	☐ 2. Decubitus Care		
	☐ 3. Sterile Protective Dressings		
	☐ 4. Turning Schedule or Repositioning		
	☐ 5. Oxygen Rx		
	☐ 6. Inhalation IPPB		
	☐ 7. Suctioning		
	☐ 8. Irrigation—Bladder		
	☐ 9. Irrigation—Other than Bladder		
	☐ 10. Ostomy Care		
	☐ 11. Enemas		
	☐ 12. Hydrotherapy (e.g., Whirlpool Baths, Soaks)		
	☐ 13. Maintenance Ambulation		
	☐ 14. Restraints		
	☐ 15. Other (Specify)		
Rehabilitation/Restorative	☐ 16. Speech Pathology/Audiology		
	☐ 17. Bowel Training		
	☐ 18. Bladder Training		
	☒ 19. Passive Exercises	q.d.	PT, R.N.
	☐ 20. Transfer Skills Training		
	☒ 21. Active Exercises (walking w/supervision)	5x Week	Aide
	☒ 22. Resistive Weight Lifting Exercises	5x Week	P.T.
	☐ 23. Gait Training		
	☐ 24. Prosthetic Training		
	☐ 25. Other (Specify)		
Teaching	☐ 26. Diet Instruction		
	☐ 27. Ostomy Care (Type)		
	☐ 28. Foot Care		
	☐ 29. Self Injection		
	☐ 30. Other (Specify)		
Psychosocial	☒ 31. Self-directed Activities	q.d.	Self
	☐ 32. Group Activities		
	☒ 33. Religious Activities	1x week	R.N.
	☐ 34. Reality Orientation Therapy		
	☐ 35. Remotivation Therapy		
	☐ 36. Behavior Modification Therapy		
	☐ 37. Social Counseling		
	☐ 38. Other (Specify)		

PATIENT CARE (Cont'd)

SAMPLE

B. Professional Visits

Was a professional visit by the attending physician or a consultant made to the patient/resident during this appraisal period.

☐ No ☒ Yes

If yes, indicate below the date(s) on which such visits were made.

		DATE(S)
☒	1. Attending Physician (M.D. or D.O.)	9/30/77
☐	2. Consultant Physician (M.D. or D.O.)	
☒	3. Dentist	9/13/77
☐	4. Optometrist or Ophthalmologist	
☐	5. Speech Pathologist/Audiologist	
☐	6. Psychologist	
☐	7. Podiatrist	
☐	8. Other (Specify) _____	

C. Medications

In the following chart, identify by name, the medication in each category actually given on the day chosen for review. Record the unit dosage (e.g., 65 mg., ii tab., 10 units, etc.), the number of times the drug was given (e.g., 1, 3, 6, etc.), and the route of administration (e.g., p.o., (H), etc.). See Appendix B. Drug Classification Guide for explanation of categories.

CATEGORY	NAME	DOSAGE	# OF TIMES	ROUTE OF ADMIN.
1. Adrenal Cortical Hormones, etc.				
2. Analgesics	Aspirin	gr X	1 x a.m.	p.o.
3. Antacids				
4. Anticoagulants				
5. Anticonvulsants				
6. Antidepressants				
7. Antidiarrheals				
8. Antihistamines				
9. Antihypertensives				
10. Anti-infectives				
11. Anti-Parkinsonism Agents				
12. Bronchodilators				
13. Cardiac Drugs	NitroBid	2.5 mg	1x	p.o.
14. Cathartics				
15. Diuretics				
16. Electrolyte/Fluid Replacements				
17. Estrogens/Androgens				
18. Expectorants/Cough Preparations				
19. EENT Preparations				
20. Insulin/Antidiabetic Agents				
21. Narcotic Analgesics				
22. Sedatives/Hypnotics	Sodium Nimbutal	100 mg	1 x h.s.	p.o.
23. Skin/Mucous Membranes				
24. Spasmolytics/Antispasmodics				
25. Stimulants				
26. Thyroid Replacements				
27. Tranquilizers				
28. Vasodilating Agents				
29. Vitamins/Minerals	Theragran M	Tab i	1x a.m.	p.o.
30. Other	Motrin	300 mg	T.i.d.	p.o.

31. Additional Drugs/Category: _____
(Use Categories 1-29 above)

Total # of Medications: 5
Total # Given by IM or IV or Subcutaneous route: _____
Total # Given that require additional supervision or care: _____
Date of Day Chosen for Appraisal Review 10 / 3 / 77
month day year

Since last appraisal, were there any manisfestations of undesired side effects or toxicity due to medications including allergic reaction, interactions, drug dependence, etc.
☐ **No** ☐ **Yes**
If yes, specify type, time of occurrence, and steps taken to alleviate the problem possible drug dependence,

When was the last time medications were reviewed? Date: 9 / 30 / 77
month day year

By whom were medications reviewed? (Check all that apply)
☒ **Pharmacist** ☐ **Physician** ☐ **Nurse**
☐ **Other, specify** _____

SCHEDULE B (Continued)

SKIN PROBLEM

SAMPLE

Appraisal Number

1 2 3 4 5 6

☐ ☒ ☐ ☐ ☐ ☐

PATIENT ID NUMBER

0 0 0 0 0 0 0 0 0

For each site of a decubitus ulcer or abnormality identified, complete one section of the chart as follows: (1) record the diameter in cms.; (2) the depth as (s) shallow or (d) deep; and (3) the status as (c) clean or (p) purulent.

1. Site	Date of Appraisal	Date of Appraisal	Date of Appraisal	Date of Appraisal	Date of Appraisal
1) Diameter					
2) Depth					
3) Status					
2. Site	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**
1) Diameter					
2) Depth					
3) Status					
3. Site	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**	**Date of Appraisal**
1) Diameter					
2) Depth					
3) Status					

Provide detail of any other skin abnormality including type such as dryness, redness, inflammation or infection, rash, or injury (abrasion, laceration, etc.) site and date of onset.

9/30/77 Coccygeal area no longer reddened

Catherine Crenski Continued

The following pages contain the PACE records of Mrs. Crenski's case, and a chronological account of her health care teams activities.

Read through the records, noting how the care plans services and activities might be similar to, or different from those developed or going on in your facility. Imagine yourself as her appraiser and a member of this patient's health care team.

Oct. 5, '77 (Care Planning Session #2)

Mrs. Crenski's health care team meets. No new problems are evident, and reappraisal data signify to the team that some of her old problems have been resolved since the date of her first care planning session. The date of this care planning session is entered opposite each problem resolved.

Using the patient's reappraisal data, and Goal Achievement Summary #1, the team discusses each goal set on Sept. 9, '77. The appraiser records the reappraisal date, the goal achievement status, the services provided, and any pertinent comments from the team's collective evaluation.

The current priority of the patient's problems appear to have changed, so the team records this new priority, establishes a goal and its target date and the plan of care for each. Care Planning form #2 documents and summarizes their actions. (Compare each problem as found on Care Planning form #1 and Care Planning form #2, and the Goal Achievement Summary #1. This exercise will give you an indication of how and why this particular health care team developed the new plan of care as summarized on Care Planning form #2.

Once Mrs. Crenski's new care plan is established, the goals and their target dates are recorded on Goal Achievement Summary form #2.

The date for the next care evaluation and planning session is set for Nov. 2, '77.

Patient's Name _____ Date Care Planning Session ____/____/____ Session No. _____
Month Day Year

Patient's ID Number | | | | | | | | | | | Date Appraisal Completed ____/____/____ Team Present _____
Month Day Year

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM

Date Next Care Planning Session ____/____/____
Month Day Year

Case CC-24
Care Planning
Session I

Patient's Name Catherine Crenski

Patient's ID Number 0 0 0 0 0 0 0 0 0

Date Care Planning Session 10 / 4 / 77 (Month / Day / Year)

Session No. 2

Date Appraisal Completed 10 / 5 / 77 (Month / Day / Year)

Team Present RN, Dietary, Aide

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM
Dx: Fracture ⓛ femur with pin. 1) walking with walker	Ambulate with care	11/4/77	Supervised independent walking	b.i.d.	RN/LPN
2) pain on movement	Eliminate pain on movement	11/4/77	Active & passive ROM - ⓛ leg	b.i.d.	PT/RN/LPN
Dietary Problems 5) Nutritional Anemia, poor appetite	Balanced adequate diet with no weight gain	11/4/77	Record Weight. Dietary Counselling to encourage proper diet. Identify acceptable food to stimulate appetite	q. 2 wk q. 2x week	Aide Dietitian
Dx: Osteoarthritis - Hands & Wrists bilateral 7) pain in hands & wrists 8) Reduced ROM hands & wrists	7&8. Increase ROM to permit activities such as hand crafts & letter writing	11/4/77	Passive & active hand exercises	b.i.d.	RN/LPN
Dx: Angina 9) Chest pain	Maintain present status	11/4/77	Monitor for change	q.d.	RN
Psychosocial Status 10) Apprehensive 11) Withdrawn 13) Depressed	10, 11, 13 - Reduce apprehension, depression & withdrawal	11/4/77	Staff to spend more time interacting with patient and encouraging her to engage in activities	q.d.	RN, LPN, Aide

Date Next Care Planning Session 11 / 5 / 77 (Month / Day / Year)

Case CC-43
Care Planning
Session II

Patient's Name Catherine Crenski Patient's ID Number 000-00-0000 Summary No. 2

Date Care Planning Session 10/5/77

GOAL ACHIEVEMENT SUMMARY

P/I/D #	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	APPRAISAL DATE	GOAL ACHIEVEMENT			SERVICES PROVIDED		Date Problem Resolved	COMMENTS
				No Change	Partial	Total	YES	NO		
1.	Walk with cane	11/4	11/4			X	X		10/25	Ambulating with cane
2.	Eliminate pain on movement	11/4	11/4		X		X			Patient continues to have some pain on movement, not as severe as before.
5.	Poor appetite	11/4	11/4		X		X			Appetite improved some
7.	Reduce pain in hands & wrists	11/4	11/4		X		X			Aspirin still used for pain
8.	Increase ROM in hands & wrists to permit activities such as crafts & letterwriting	11/4	11/4		X		X			Can write letters
9.	Prevent occurance of Angina	11/4	11/4		X		X			has had mild angina on several occasions
10, 11, 13	Reduce apprehension withdrawal and depression	11/4	11/4		X		X			Patient continues to show improvement in these areas.

Oct. 31, '77

Mrs. Crenski's reappraisal (Appraisal III) is begun

Nov. 4, '77

Mrs. Crenski's reappraisal (Appraisal III) is completed.

The reappraisal (Appraisal III) data are found on the following pages (p. 47-55).

PATIENT APPRAISAL DATA

SAMPLE
See Instructions pp. 53-54

Appraisal Number
1 2 3 4 5 6
☐ ☐ ☒ ☐ ☐ ☐

PATIENT ID NUMBER
0 0 0 0 0 0 0 0 0

PACE APPRAISER: Jane Doe, R.N.
Name and Discipline

Beginning Date of Appraisal 10/31/77

Type of Appraisal ☐ Admission/Initial ☐ Periodic
☐ Routine (Annual) ☒ Discharge
☐ Other (Specify) _____

1 Present Level of Care (Check appropriate box)
☒ Skilled Nursing Care
☐ Intermediate Care
☐ Other (Specify) _____

2. Present Reimbursement Source(s). Indicate in the space provided whether (P) principal or (S) supplemental; (unless a change has occurred since last appraisal, omit this question)

____ Medicare (Title XVIII)	____ All Other Public Sources
____ Medicaid (Title XIX)	____ Blue Cross or Commercial Health Insurance
____ Social Services (Title XX)	____ Self Pay
____ V.A.	____ No Charge
____ Workers' Compensation	____ Not Determined

3 Have any incidents or accidents occurred involving this patient since the last appraisal?
☒ No ☐ Yes
If yes, give details _____

4 Has there been a significant change in the individual's physical or emotional status since the last appraisal?
☒ No ☐ Yes
If yes, give details _____

5. Rehabilitation Potential:
a Is there a possibility of restoring the indivdual from his/her present physical and/or emotional functional level to a higher level of function? (check appropriate box)
☐ No ☒ Yes
b If yes, explain in what functional areas this is possible climbing stairs
c If no, is there a possibility of preventing deterioration of the present physical and/or emotional state to sustain the individual's current capacities? (check appropriate box)
☐ No ☐ Yes
d If yes, specify the functional areas _____
e If no, is there a possibility of slowing down the process of deterioration? (check appropriate box)
☐ No ☐ Yes
f If yes, specify the functional areas _____

6 If improving, is discharge anticipated within one month?
☐ No ☒ Yes
If yes, complete Schedule C

Fill in this section at end of appraisal.
Check appropriate box(es) indicating the professional discipline of persons contributing to this appraisal:

☒ R.N.	☐ Social Worker
☒ L.P.N.	☒ Physical Therapist
☒ Aide/Orderly	☐ Occupational Therapist
☐ Other, specify _____	

PACE Appraiser's signature Jane Doe, R.N.

Date of Completion of Appraisal 11 / 4 / 77
month day year

NOTES

IMPAIRMENTS

SAMPLE
See Instructions pp. 54-58

Appraisal Number
1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER
0 0 0 4 0 0 0 0

A. Skin

1. **Are there any decubitus ulcers present at this appraisal:** ☒ **No** ☐ **Yes**
   If yes, indicate number of sites _____
2. Are there any other skin abnormalities. ☒ **No** ☐ **Yes**
   If Item 1 and/or 2 is answered yes, complete Schedule B

B Extremities and Trunk

Are there any missing limbs or fracture/dislocation of the hip or other bone. ☐ **No** ☐ **Yes**
If yes, complete the following chart.

EXTREMITY		MISSING LIMBS Date of amputation, and Type: (BE) Below Elbow (AK) Above Knee (AE) Above Elbow (P) Prosthesis (BK) Below Knee	FRACTURED HIP(S) Date of Repair (R) or Prosthesis	OTHER FRACTURES/ DISLOCATIONS Date and Location
UPPER	R			
	L			
LOWER	R			
	L		Healed fx (L) femur 8/11/77	

C Sensory/Communication Status (check appropriate box(es))

1 Vision (with glasses if customarily used)
☒ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
☐ **b. Moderate loss** ☐ **d. Total blindness**

2 Hearing (with hearing aid if customarily used)
☒ **a. Normal or minimum loss** ☐ **c. Severe loss** ☐ **e. Not determined**
☐ **b. Moderate loss** ☐ **d. Total deafness**

3. Expressive Communication
Select the one category that best describes the **usual** method used by the patient in conveying information.
☒ **a. Speaks and is usually understood** ☐ **d. Uses gestures, grunts, or primitive symbols**
☐ **b. Speaks but is understood only with difficulty** ☐ **e. Does not convey needs**
☐ **c. Uses structured sign language, symbol board, or writes** ☐ **f. Not determined**

4. Receptive Communication
Select the one category that best describes the patient's **usual** method of understanding information conveyed by others.
☒ **a. Hears and usually understands** ☐ **e. Does not understand**
☐ **b. Hears and understands only with difficulty** ☐ **f. Not determined**
☐ **c. Depends on lip reading, written materials, or structured sign language**
☐ **d. Understands only primitive gestures, facial expressions or simple pictograms and/or recognizes environmental cues**

D. Bowel/Bladder Status

1. Is there bowel incontinence:
☒ **No** ☐ **Yes**
If yes, specify frequency of incidents _____
2. Are there any other bowel problems such as ostomy.
☒ **No** ☐ **Yes**
If yes, specify _____
If yes, is assistance needed? ☐ **No** ☐ **Yes**
3. Is there bladder incontinence:
☒ **No** ☐ **Yes**
If yes, specify frequency of incidents _____
4. Are there any other bladder problems such as ostomy, indwelling catheter or external device:
☒ **No** ☐ **Yes**
If yes, specify _____
If yes, is assistance needed? ☐ **No** ☐ **Yes**

PHYSICAL FUNCTION

SAMPLE
See Instructions pp. 58-86

Appraisal Number

1	2	3	4	5	6
☐	☐	☒	☐	☐	☐

Note—During any of the specified tests in Section A—Range of Motion and Section B—Strength, Balance, and Coordination, if the client indicates pain on motion, stop that portion of the test immediately. Proceed to another test. If tests in these sections are medically contraindicated, give reasons:

_____ **Date** __/__/__

_____ **Date** __/__/__

A. Range of Motion

With patient lying on back on bed, test passive movements of upper and lower extremities for full range of motion. Indicate by check in the chart below if there is restriction and/or disabling condition in any extremity. Specify other observations in the space provided.

PARTS OF THE BODY	RESTRICTED						OTHER OBSERVATIONS
	FLEXION A	EXTENSION B	ABDUCTION C	ADDUCTION D	ROTATION E	F.	
1 Right Extremities							
a. Fingers/Thumb	✓	✓					
b. Wrist	✓	✓					
c. Elbow							
d. Shoulder							
e. Ankle							
f. Knee							
g. Hip							
2. Left Extremities							
a. Fingers/Thumb	✓	✓					
b. Wrist	✓	✓					
c. Elbow							
d. Shoulder							
e. Ankle							
f. Knee	✓	✓					
g. Hip	✓	✓	✓	✓	✓		

3. Head and Trunk

With patient sitting unsupported on side of bed, test range of motion of head and trunk. If patient cannot sit unsupported on side of bed for any reason, indicate in the margin that the test was not done. If appropriate, complete test at a later date.

Is there any restriction and/or disabling condition in head or trunk?
☐ **No** ☐ **Yes**
If yes, place a check mark in each applicable box; specify other observations.

	Side to Side	Flexion	Extension	Other Observations
a. Head				
b. Trunk				

PHYSICAL FUNCTION (Cont'd)

SAMPLE

Appraisal Number
1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER
0 0 0 0 0 0 0 0 0

B. Strength, Balance, and Coordination

Note—(1) If the client is bed-bound or chair-bound, complete only those test items that can be performed under those conditions; (2) observe balance and coordination (Item 7-8) while testing items 1-6; (3) perform tests and check as applicable; and (4) specify other observations.

1. Patient can dorsiflex foot, and with knee extended, raise leg 10 inches from bed, hold 5 seconds, lower to bed.
   Right Leg: ☒ Yes ☐ No Left Leg: ☐ Yes ☒ No
   Other Observations STILL Some weakness
2. Patient can roll from supine to prone in each direction.
   Right to Left: ☒ Yes ☐ No Left to Right: ☒ Yes ☐ No
   Other Observations Apprehension Re: Falling somewhat subdued
3. Patient can sit up unassisted, swing legs over side of bed and return. ☒ Yes ☐ No
   Other Observations
4. Patient can grasp examiner's hand with normal strength hand grip.
   Right Hand: ☒ Yes ☐ No Left Hand: ☒ Yes ☐ No
   Other Observations
5. Patient can stand erect having used chair arms for support. ☒ Yes ☐ No
   Other Observations
6. Patient can stand erect unsupported, and with elbows extended, raise both arms above head, hold for 5 seconds.
   ☐ Yes ☐ No
   Other Observations Needs cane to stand unsupported - not tested
7. Patient appears to have normal balance when sitting unsupported and standing unsupported.
   Sitting: ☒ Yes ☐ No Standing: ☐ Yes ☒ No
   Other Observations
8. Patient appears to have normal coordination when moving body parts. ☒ Yes ☐ No
   Other Observations

Review questions in Section A—Range of Motion and Section B—Strength, Balance, and Coordination. If any restrictions and/or impairments are observed, the patient should be seen by a physical or occupational therapist for a more thorough examination.

C. Activities of Daily Living

Indicate the level of performance by placing a check in every column that applies. Think of these functional abilities in relation to the individual's rehabilitation potential when answering parts of question 5 on page 3 of this instrument.

FUNCTION	A NO PROBLEM	B MECHANICAL AID	C HUMAN HELP	D # PERSONS HELPING	E DOES NOT PERFORM	F. REMARKS
1 MOBILITY						
a Goes Outside		X				With use of cane
b Walking		X				Uses cane
c Climbing Stairs					X	potential for rehab good
d Transferring	X					
e Wheeling	X					
2 PERSONAL CARE						
a Bathes/Showers	X					
b Toileting		X				
c Dressing	X					
d Grooming	X					
e Eating	X					

DENTAL/ORAL STATUS

SAMPLE

Appraisal Number

1 ☐ 2 ☐ 3 ☒ 4 ☐ 5 ☐ 6 ☐

Use a tongue depressor or dental mirror and flashlight to make the examination. Check all boxes that apply and record other problems in space provided to describe condition of the mouth. (See instructions pp. 96-97)

	None	1-10	11+	Satisfactory	Decay	Fracture	Pain	Loose	Unclean
Natural Teeth									
Dentures Complete or Partial	None	Upper Uses: Partial ✓	Lower Uses: Complete ✓	Satisfactory	Broken	Missing Teeth	Uncomfortable	Loose	Unclean

				Ulcer, Sore, Lump, or Other Lesion					
Oral Soft Tissues	Normal	Gums Inflamed	Dry Mouth	Tongue	Under Tongue	Lips	Palate	Cheeks	Gums
	✓								

Other Dental/Oral Problems _____

NUTRITIONAL STATUS

See Instructions pp. 97-99

1 Is there a special diet prescribed?
☐ **No** ☒ **Yes**
If yes, check appropriate diet(s) listed below
☐ **a. Mechanical Soft Diet**
☐ **b. Bland-Low Residue Diet**
☐ **c. Diabetic Diet**
☐ **d. Calorie Restricted Diet**
Specify calorie level _____
☐ **e. Sodium Restricted Diet**
☐ **f. Fat Modified Diet**
☐ **g. Other, specify** _____

2. Is there an intake problem?
☒ **No** ☐ **Yes**
If yes, check those that apply below
☒ **a. Solid Food Problem (Specify)** Appetite poor but continues to improve
☐ **b. Fluid Intake Problem (Specify)** _____

3. Is there an output problem?
☒ **No** ☐ **Yes**
If yes, check those that apply below.
☐ **a. Constipation**
☐ **b. Diarrhea**
☐ **c. Fluid Retention**
☐ **d. Other (Specify)** _____

4. Are there food likes or dislikes?
☐ **No** ☒ **Yes**
If yes, complete the folowing:
a Are they recorded? ☒ **Yes** ☐ **No**
b Are they carried out? ☐ **Yes** ☒ **No** substitutes offered

5. Are there cultural/religious constraints? ☐ **No** ☒ **Yes**
If yes, complete the folowing:
a. Are they recorded? ☒ **Yes** ☐ **No**
b. Are they carried out? ☐ **Yes** ☒ **No** Kosher food still unavailable

6. Are supplementary nourishments given, e.g., a high protein commercial preparation ☐ **No** ☒ **Yes**
If yes, specify Ensure, 240 cc T.i.d.

7. What is the usual dining location? dining room

8. Weight (this appraisal) 119

9. Has there been a recent weight change? ☒ **No** ☐ **Yes**
* If yes, specify whether gain or loss and how much. _____

PSYCHOSOCIAL FACTORS

SAMPLE
See Instructions pp. 99-102

Appraisal Number
1 ☐ 2 ☐ 3 ☑ 4 ☐ 5 ☐ 6 ☐

PATIENT ID NUMBER

A. Patient's Adjustment to Care Plan

Note: The following items may not be applicable to a newly admitted patient. If care plan has not been developed on first appraisal, omit this item and write N.A. in the margin. Complete on subsequent appraisals when care plan has been developed.

ITEM	PATIENT		FAMILY/SURROGATE	
	YES	NO	YES	NO
1. Involved in care planning	X		X	
2. Cooperated actively—with positive attitude and enthusiasm	X			
3. Cooperated passively—made no inputs, but carried out plan		X		
4. Found fault with some items in the care plan but followed plan		X		
5. Found fault with items in the care plan and refused to cooperate		X		
6. Was provided with an educational experience explaining the rationale for the treatment and care plan	X		X	

B. Patient's Social Interaction and Adjustments to the Facility

Describe the pattern of behavior for the individual by checking the appropriate column for each item.

ITEM	USUALLY	OCCASIONALLY	NEVER
1. Is oriented to the time and space of his/her living environment.	✓		
2. Cooperates with rules and regulations.	✓		
3. Asserts self and makes needs known.	✓		
4. Participates in self-directed activities.	✓		
5. Personalizes living space.	✓		
6. Personalizes apparel.	✓		
7. Participates in structured activity program.	✓		
8. Eats in dining room (if physically capable).	✓		
9. Spends free time outside his/her own room.	✓		
10. Has visitors from outside the facility.	✓		
11. Visits others outside the facility.	✓		
12. Has outside contacts, i.e., letters, calls, etc..	✓		
13. Talks about events that go on outside the facility	✓		
14. Engages in conversation with staff.	✓		
15. Engages in conversation with fellow patients.	✓		
16. Relates in an appropriate adult manner to fellow patients.	✓		
17. Relates in an appropriate adult manner to staff.	✓		

C. Behavioral Problems

Describe the usual manner of behavior for the individual by checking the appropriate column for each item (1-15). Indicate in Column A those behaviors which have not been exhibited; and in Column B those that have been exhibited by the patient and specify by checking the appropriate box which of those behaviors interfere with the functional capacity, require special care, and/or supervision. (See definitions pp. 102-103)

BEHAVIORS	(A) DOES NOT EXHIBIT	(B) EXHIBITS	
		DOES NOT INTERFERE	INTERFERES
1. Apprehensive (slightly)		✓	
2. Withdrawn			
3. Hyperactive			
4. Abusive to self			
5. Disruptive			
6. Hostile			
7. Abusive to others			
8. Wanders			
9. Forgetful			
10. Confused			
11. Delusional			
12. Hallucinates			
13. Emotionally labile			
14. Depressed			
15. Inappropriate behavior, other specify _____			

If the individual's adjustment to the care plan, his/her social interaction and adjustment to the facility, or behavioral characteristics affect his/her functional capacity or necessitate additional care and/or supervision, then consideration should be given to having the patient examined by a psychiatrically oriented professional such as a psychiatric or other qualified social worker, psychiatric nurse, clinical psychologist or psychiatrist.

Patient expresses slight apprehension re: potential discharge and ability to function alone.

PATIENT CARE

SAMPLE
See Instructions pp. 103--109

Appraisal Number

1 2 3 4 5 6

☐ ☐ ☒ ☐ ☐ ☐

A. Special Procedures
For each procedure listed below, check those given at the time of this appraisal, and indicate the frequency performed and by whom.

	PROCEDURE	FREQUENCY	BY WHOM
General Nursing Care	☐ 1. Preventive Skin Care		
	☐ 2. Decubitus Care		
	☐ 3. Sterile Protective Dressings		
	☐ 4. Turning Schedule or Repositioning		
	☐ 5. Oxygen Rx		
	☐ 6. Inhalation IPPB		
	☐ 7. Suctioning		
	☐ 8. Irrigation—Bladder		
	☐ 9. Irrigation—Other than Bladder		
	☐ 10. Ostomy Care		
	☐ 11. Enemas		
	☐ 12. Hydrotherapy (e.g., Whirlpool Baths, Soaks)		
	☐ 13. Maintenance Ambulation		
	☐ 14. Restraints		
	☐ 15. Other (Specify)		
Rehabilitation/Restorative	☐ 16. Speech Pathology/Audiology		
	☐ 17. Bowel Training		
	☐ 18. Bladder Training		
	☒ 19. Passive Exercises	q.d.	PT, RN
	☐ 20 Transfer Skills Training		
	☒ 21. Active Exercises (walking)	q.d.	Aide
	☒ 22. Resistive Weight Lifting Exercises	5 x week	PT
	☐ 23. Gait Training		
	☐ 24. Prosthetic Training		
	☐ 25. Other (Specify)		
Teaching	☐ 26. Diet Instruction		
	☐ 27 Ostomy Care (Type)		
	☐ 28. Foot Care		
	☐ 29. Self Injection		
	☐ 30. Other (Specify)		
Psychosocial	☒ 31. Self-directed Activities	q.d.	Self
	☐ 32. Group Activities		
	☒ 33. Religious Activities	2 x week	Aide
	☐ 34 Reality Orientation Therapy		
	☐ 35. Remotivation Therapy		
	☐ 36. Behavior Modification Therapy		
	☐ 37. Social Counseling		
	☐ 38. Other (Specify)		

PATIENT CARE (Cont'd)

SAMPLE

B. Professional Visits

Was a professional visit by the attending physician or a consultant made to the patient/resident during this appraisal period.

☐ **No** ☒ **Yes**

If yes, indicate below the date(s) on which such visits were made.

		DATE(S)
☒	1. Attending Physician (M.D. or D.O.)	10/31/77
☐	2. Consultant Physician (M.D. or D.O.)	
☐	3. Dentist	
☐	4. Optometrist or Ophthalmologist	
☐	5. Speech Pathologist/Audiologist	
☐	6. Psychologist	
☐	7. Podiatrist	
☐	8. Other (Specify)	

C. Medications (See Instructions pp. 108-109)

In the following chart, identify by name, the medication in each category actually given on the day chosen for review. Record the unit dosage (e.g., 65 mg., ii tab., 10 units, etc.), the number of times the drug was given (e.g., 1, 3, 6, etc.), and the route of administration (e.g., p.o., (H), etc.). See Appendix B. Drug Classification Guide for explanation of categories.

CATEGORY	NAME	DOSAGE	# OF TIMES	ROUTE OF ADMIN.
1. Adrenal Cortical Hormones, etc.				
2. Analgesics	Aspirin	gr X	1 x a.m.	p.o
3. Antacids				
4. Anticoagulants				
5. Anticonvulsants				
6. Antidepressants				
7. Antidiarrheals				
8. Antihistamines				
9. Antihypertensives				
10. Anti-infectives				
11. Anti-Parkinsonism Agents				
12. Bronchodilators				
13. Cardiac Drugs	Nitro Bid	2.5 mg	1 x	p.o.
14. Cathartics				
15. Diuretics				
16. Electrolyte/Fluid Replacements				
17. Estrogens/Androgens				
18. Expectorants/Cough Preparations				
19. EENT Preparations				
20. Insulin/Antidiabetic Agents				
21. Narcotic Analgesics				
22. Sedatives/Hypnotics	Sodium Nimbutal	100 mg	1 x h.s.	p.o.
23. Skin/Mucous Membranes				
24. Spasmolytics/Antispasmodics				
25. Stimulants				
26. Thyroid Replacements				
27. Tranquilizers				
28. Vasodilating Agents				
29. Vitamins/Minerals	Theragram M	Tab i	1 x am	p.o.
30. Other	Motrin	300 mg	T.i.d.	p.o.

31. Additional Drugs/Category: _____
(Use Categories 1-29 above) _____

Total # of Medications: 5
Total # Given by IM or IV or Subcutaneous route: _____
Total # Given that require additional supervision or care: _____
Date of Day Chosen for Appraisal Review 11 / 3 / 77
month day year

Since last appraisal, were there any manisfestations of undesired side effects or toxicity due to medications including allergic reaction, interactions, drug dependence, etc.

☒ **No** ☐ **Yes**

If yes, specify type, time of occurrence, and steps taken to alleviate the problem _____

When was the last time medications were reviewed? Date: 10 / 31 / 77
month day year

By whom were medications reviewed? (Check all that apply)

☒ **Pharmacist** ☐ **Physician** ☒ **Nurse**
☐ **Other, specify** _____ Reviewed together

SCHEDULE C

Appraisal Number

1	2	3	4	5	6
☐	☐	☒	☐	☐	☐

PATIENT ID NUMBER

0 0 0 0 0 0 0 0 0

Once the physician has determined that the patient has Discharge Potential, Schedule C should be used for Discharge Planning. This Schedule has space at the end for a brief summary. Date all entries.

DETAILS OF READINESS FOR DISCHARGE

1. Ability to Carry out IADLs

Indicate the level of performance for the following Instrumental Activities of Daily Living (IADLs) by placing a check in every column that applies. In addition, summarize other observations and specific problems in completing each task.

IADL	A. NO PROBLEM	B. HUMAN HELP	C. # PERSONS HELPING	D. DOES NOT PERFORM	E. REMARKS
1. Using the telephone	✓				
2. Handling money	✓				
3. Securing personal items		✓	1		Difficulty where stairs are present
4. Tidying up*		✓	1		Apprehensive of moving about too much when alone
5. Preparing simple meals	✓				

2. Availability of Caretaker (Check most applicable)

☐ Patient/resident needs no care
Patient/resident needs care and;
☒ Family/others able and will provide
☐ Family/others available but not able to provide
☐ Family/others not available

3. Residence (Check most applicable)

☒ Living space available and adequate
☐ Living space available but not adequate
☐ Living space not available

* Includes housekeeping chores, such as making a bed, cleaning, picking up objects from the floor, and vacuuming carpets.

SCHEDULE C—READINESS FOR DISCHARGE (Cont'd)

PATIENT ID NUMBER

0 0 0 0 0 0 0 0 0

A. PATIENT STATUS INFORMATION

4. The patient/resident performs all Activities of Daily Living (ADL) without assistance or assistance will be provided by others:
☐ yes ☒ no (Refer to Physical Function, Part C Chart)

If answer to item 1 is no, what ADLs does patient/resident need assistance with? (Specify) _____
Performs all ADLs except unable to climb stairs.

What plans are being made to provide the needed assistance? (Specify) Will be in a senior citizens apartment complex - Living space one floor.

5. The patient/resident has no service needs or needs will be met by others: ☒ yes ☐ no

If answer to item 2 is no, what service needs are required? (Specify) _____

What plans are being made to provide the needed services? (Specify) _____

6. The patient/resident performs all Instrumental Activities of Daily Living without assistance or assistance will be provided by others:

☒ yes ☐ no (Refer to IADL Chart)

If no, what plans are being made to provide the needed assistance? (Specify) _____

7. The patient/resident has funds (personal and/or other) available and can be used:

☒ yes ☐ no

If no, what funds are needed? (Specify) _____

What plans are being made to obtain needed funds? (Specify) _____

SCHEDULE C (Continued)

8. With whom were discharge plans discussed? (Check all that apply)

☒ Patient ☒ Family ☒ Physician ☐ Social Worker

☒ Other person (Specify) Somerville Senior Citizens Residence

9. With which, if any, were discharge plans discussed?

Community Resource Agencies (Specify) _____

Other Resource Agencies (Specify) _____

10. Discharge summary (include diagnoses, summary of course of prior treatment, and rehabilitation potential)

Fractured (L) Femur pinned - healed
Angina Pectoris
Osteo arthritis - hands and wrists - bilateral -
Mrs. Crenski fell 8/11 and fractured the neck of her (L) femur. After a hip pinning she was admitted 9/1 to this facility. She is alert & although she was apprehensive and depressed on admission she continues to show improvement in these areas. She has expressed slight apprehension re: planned discharge. She has received P.T. daily & is currently ambulating with a cane. She is still unable to climb stairs. Mrs. Crenski has experienced several episodes of chest pain, related to stressful situations, which has been relieved by nitroglycerine. She is taking Nitro Bid, 2.5 mg, daily. Mrs. Crenski will be discharged to a one floor apartment in a senior citizen's residence. Arrangements have been made for a home-maker to clean the apartment weekly. Her daughter will shop for her and visit @ least every other day. Mrs. Crenski has been discharged by her Orthopedic doctor but has an appointment with her family physician in two weeks. She will be discharged on the following medication:

Aspirin gr. X p.r.n.
Nitro Bid 2.5 mgm q.d.
Nitroglycerine T tab p.r.n. for chest pain
Theragran M Tab T q.d.m.
Matria 300 mgm T.i.d.

Nov. 5, '77 (Care Planning Session #3)

Mrs. Crenski's health care team meets.

The patient's plan shows no additions, but reappraisal data indicate that some of her old problems have been resolved. The date of this care planning session is entered as the date of resolution.

Using the Goal Achievement Summary form #2 and the patient's reappraisal data, the team discusses each problem, the goal set to resolve the problem and the care that the patient has received to resolve the problem. The appraiser records the reappraisal date, the status of Goal Achievement, and any pertinent comments.

The health care team decides that the priority of the patient's problems remains unchanged, and that the care appears to be improving the patient's functioning capacities. Care Planning Session #3 records show that this team has chosen to have the patient continue with the priorities, goals and plan of care established in Care Planning Session #2. As the discharge plans are made, they are recorded on Schedule C.

Patient's Name _____ Date Care Planning Session ____/____/____ Session No. _____
Month Day Year

Patient's ID Number | | | | | | | | | | | Date Appraisal Completed ____/____/____ Team Present _____
Month Day Year

CARE PLANNING

PROBLEM/IMPAIRMENT/ DYSFUNCTION (P/I/D)	LONG RANGE GOAL OR STEP TOWARD GOAL	TARGET DATE	PLAN OF CARE		
			WHAT	FREQ.	BY WHOM

Date Next Care Planning Session ____/____/____
Month Day Year

APPENDIX E
Comparison of Basic Data Set and PACE II

APPENDIX E

Comparison of Basic Data Set and PACE II

A wide variety and scope of information is needed to evaluate and implement national policy and planning, manage State and local nursing home programs, and make decisions about individual patient care. On the one hand, providers need detailed information about patient status and evaluation. Whereas, State and national planners need less detailed information from a large patient population and service delivery system. Aggregate data concerning need, demand, and utilization of the long-term care population are essential for effective health systems.

The National Center for Health Statistics of the Department of Health, Education, and Welfare, has proposed a Minimum Basic Data Set (MBDS) on long-term care for the purpose of creating a core data set and common language that can be used for long-term care policy and planning. The Minimum Basic Data Set was formulated to provide a set of demographic, client-centered data items that can be easily obtained, recorded, and transcribed with accuracy and economy. Because of the need to promulgate useful and consistent data collection systems, the data elements and definitions of the MBDS and PACE II were developed congruently. A list of items found in both the PACE II instrument and the Minimum Basic Data Set form are compared in the following chart for the convenience of the reader. The pages of the Patient Care Management manual on which the Minimum Basic Data Set items can be found are noted; the corresponding pages of definitions in the manual are listed under "Definition Page."

	Basic Data Set Item	PACE II Item	PACE Page	Definition Page
1.	Personal Identification	Patient Identification	11	43
2.	Sex	Same	11	44
3.	Birth Date	Date of Birth	11	44
4.	Race/Ethnicity	Same	11	44
5.	Marital Status	Current Marital Status	11	45
6a.	Usual Living Arrangement, Type	Usual Living Arrangement and Usual Residence—Similar	11	45, 46
6b.	Usual Living Arr., Location	Residence/Location	11	46
7.	Court Ordered Constraints	Same	11	46
8.	Vision	Same	15	56
9.	Hearing	Same	15	56, 57
10.	Communication	Expressive Communication and Receptive Communication	15	57
11.	Basic Activities of Daily Living	Activities of Daily Living—Similar, Bowel/Bladder status—Similar	19 15	88 57, 58
12.	Mobility	Activities of Daily Living—Similar	19	89
13.	Adaptive Tasks	Schedule C—Readiness for Discharge	33-35	—
14.	Disruptive Behavior	Behavior Problems—Similar	22	102
15.	Disorientation/Memory Impairment	Client's Social Interaction and Adjustments to the facility	22	—
16.	Disturbances of Mood	Behavioral Problems—Similar	22	102
17.	Primary and Other Significant Diagnoses	Medically Defined Conditions	12	47–51
18.	Provider Identification	Same	11	43
19.	Last Principal Provider	Same	11	43
20.	Date of Admission	Date of Latest Admission	11	43
21.	Direct Services	See Patient Care	23	103-105
22.	Principal Source of Payment	Reimbursement Sources	13	53, 54
23.	Charges	Not Included in PACE II	—	—
24.	Discharge/Termination of Service	Discharge Data—Similar	11	46, 47

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